Trends and Imperatives in Mental Health Service Provision: A Workforce Learning and Development Needs Analysis

Phase Two: Report

Brenda Roe
Kevin Corbett
Mairi Byrne
Helena McCourt
Julie Chadwick
Annette Jinks

September 2009
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Team</td>
<td>3</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td><strong>EXECUTIVE SUMMARY</strong></td>
<td>4-5</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td>6-8</td>
</tr>
<tr>
<td>Background</td>
<td>6</td>
</tr>
<tr>
<td>Context</td>
<td>7</td>
</tr>
<tr>
<td><strong>METHODS</strong></td>
<td>9-13</td>
</tr>
<tr>
<td>Research Questions and Objectives</td>
<td>9</td>
</tr>
<tr>
<td>Design</td>
<td>9</td>
</tr>
<tr>
<td>Populations and Samples</td>
<td>10</td>
</tr>
<tr>
<td>Methods of Data Collection</td>
<td>10</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>13</td>
</tr>
<tr>
<td>Data Management and Analysis</td>
<td>13</td>
</tr>
<tr>
<td>Reliability and Validity</td>
<td>13</td>
</tr>
<tr>
<td><strong>FINDINGS</strong></td>
<td>14-56</td>
</tr>
<tr>
<td>Participants</td>
<td>14</td>
</tr>
<tr>
<td>Key Findings</td>
<td>16</td>
</tr>
<tr>
<td>Policy and Organisational Drivers</td>
<td>17</td>
</tr>
<tr>
<td>Learning and Development Needs</td>
<td>18</td>
</tr>
<tr>
<td>Challenges and Opportunities for Future Mental Health Services</td>
<td>54</td>
</tr>
<tr>
<td><strong>DISCUSSION</strong></td>
<td>57-61</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>57</td>
</tr>
<tr>
<td>Modernisation Agenda</td>
<td>57</td>
</tr>
<tr>
<td>Quality, Outcomes and Business Principles</td>
<td>58</td>
</tr>
<tr>
<td>Learning, Development and Workforce Planning</td>
<td>59</td>
</tr>
<tr>
<td>Skills and Competences</td>
<td>60</td>
</tr>
<tr>
<td><strong>CONCLUSION</strong></td>
<td>61</td>
</tr>
<tr>
<td><strong>RECOMMENDATIONS</strong></td>
<td>62-64</td>
</tr>
<tr>
<td>Service Users and Carers Involvement</td>
<td>62</td>
</tr>
<tr>
<td>Organisational and Staff Developments</td>
<td>62</td>
</tr>
<tr>
<td>Commissioning Learning and Development, Collaboration and Partnership Working</td>
<td>63</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>65-67</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Questions Included in Stakeholder Interviews</td>
<td>11</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Questions Used in the Staff Focus Groups</td>
<td>12</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Questions Used in the Service User and Carer Focus Groups</td>
<td>12</td>
</tr>
<tr>
<td>Figure 4</td>
<td>List of National and Local Policy and Organisational Drivers Identified by Respondents (alphabetical order)</td>
<td>17</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Learning and Development Needs/Challenges (all respondents)</td>
<td>18</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Summary of Emergent Themes for Learning and Development (all respondents)</td>
<td>19</td>
</tr>
<tr>
<td>Figure 7</td>
<td>Specific Challenges and Opportunities for Future Mental Health Services</td>
<td>55</td>
</tr>
</tbody>
</table>

LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Response Rates for Focus Groups According to Trust</td>
<td>14</td>
</tr>
<tr>
<td>Table 2</td>
<td>Participants in Focus Groups Clinical Area and Role According to Trust</td>
<td>15</td>
</tr>
<tr>
<td>Table 3</td>
<td>Participants in Focus Groups Professional and Academic Qualifications According to Trust</td>
<td>16</td>
</tr>
</tbody>
</table>
Project Team

Professor Brenda Roe, Professor of Health Research, Evidence-based Practice Research Centre, Faculty of Health, Edge Hill University, St Helens Rd, Ormskirk, Lancashire L39 4QP Email: roeb@edgehill.ac.uk Tel No: 01695 650948

Dr Kevin Corbett, Independent Research Consultant, Unit 7, 1-10 Summers Street, London EC1R 5BD Email: drkevinpcorbett@tiscali.co.uk Tel No: 07840 820 446

Mairi Byrne, Head of Department, Mental Health and Learning Disabilities, Faculty of Health, Edge Hill University, St Helens Rd, Ormskirk, Lancashire L39 4QP Email: byrnem@edgehill.ac.uk Tel No: 01695 650 7775

Helena McCourt, Deputy Director of Nursing, Mersey Care NHS Trust, Maghull, Email: Helena.Mccourt@merseycare.nhs.uk Tel No: 07773 764970

Julie Chadwick, Head of Learning & Development, 5 Borough Partnerships NHS Trusts, Hollins Park, Warrington. Email: Julie.Chadwick@5bp.nhs.uk Tel No: 01925 664405

Professor Annette Jinks, Professor of Nursing, Evidence-based Practice Research Centre, Faculty of Health, Edge Hill University, St Helens Rd, Ormskirk, Lancashire L39 4QP Email: jinksa@edgehill.ac.uk Tel No: 01695 650946

Acknowledgements: The project was commissioned and funded by Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust from the Faculty of Health, Edge Hill University. We are grateful to all those who participated in the project and thank them for their time, commitment and support. Thank you also to Iris Benson, for invaluable advice and support as a Service User and Carer Representative and involvement in project management meetings.
EXECUTIVE SUMMARY

As part of a novel joint initiative Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust commissioned the Faculty of Health, Edge Hill University to undertake a Workforce Learning and Development Needs Analysis in order to assist their development of future Workforce Learning and Development Strategies. This project was undertaken during 2008 to 2009 and was collaboration on behalf of the Trusts and included staff from the Trusts, the Faculty of Health and its Evidence-based Practice Research Centre. The project comprised two phases; an initial phase where a systematic policy and literature review was conducted to identify the key drivers of current and future mental health service provision, reported on in 2008, followed by a second phase which obtained the views and perspectives of staff within the Trusts and service user and carer representatives on current and future mental health services provision and learning and development needs. This is the report of the second phase.

The review demonstrated there are key national policy drivers that are influencing the organisation and delivery of mental health services provision and their future development as well as those staff responsible for providing care and managing the services. The next phase of the study has involved undertaking interviews and focus groups with key stakeholders including Trust directors, staff, and service user and carer representatives. Eight interviews and 12 focus groups were conducted, which involved convenience samples of directors from each Trust being interviewed as well as staff involved with Learning and Development Forums, or those interested in participating in the study (n=50) and service users and carers (n=14) in the focus groups. This has allowed the views and perspectives to be gained from corporate and strategic levels as well as administrative, professional and service users. Three key research questions were addressed;

- What are the trends and imperatives in mental health service provision and how do they impact on current and future learning and development needs of staff employed at Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust?

- What are Directorate managers and staff employed at Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust personal and occupational group perspectives of current and future learning and development needs of the workforce to meet the changes and services developments in mental health provision?

- What are representatives of service user and carers’ views on current and future learning and development needs of the workforce to meet services development in mental health service provision?

Thematic analysis of the qualitative data obtained was undertaken and key findings identified related to policy and organisational drivers, learning and development needs and challenges and opportunities for future mental health
services. A summary of the key emergent themes for learning and development include:

- Modernisation
- Quality, outcomes and business principles
- Power of commissioning
- Commissioning learning and development
- The multiplicity of stakeholders
- Role development and career progression
- Skills and competences
- ‘ Newly Qualifieds’
- Corporate workforce planning
- Corporate role in learning and development
- Learning and development provision
  - Service user/carer’s learning and development
  - Trust provision
  - Partnership provision

The findings have been discussed in relation to the key local and national policies, and opportunities and challenges faced by the Trusts. The challenges identified require vision and collaborative working, recognising the unique care needs of clients and the learning and development required for staff, organisations, local populations and the public. These constitute opportunities for developing future mental health services as part of the modernisation agenda, with a focus on outcomes and quality and workforce planning, learning and development based on skills and competences as well as business principles.

The study has provided evidence, which the Trusts can use to take forward and inform their Workforce Planning, and Learning and Development Strategies. Recommendations have been made which the Trusts can take forward individually, in collaboration or on behalf of each other as partners. The range of these issues is broad and involves new ways of organising and delivering services, commissioning, inter-agency and partnership working, modernisation, staff development, service user and carer involvement, person and family centred care with outcomes focused on prevention, mental health and well-being, recovery and self-care. They also represent further opportunities for the Trusts to develop mental health services responsive to the needs of local populations that are fit for purpose and of value.
INTRODUCTION

This project was commissioned by Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust from Edge Hill University to assist them in developing their future Workforce Learning and Development Strategies by obtaining information on their workforce development needs. The broad aim of this evaluation research was to identify current learning and development needs of staff in mental health service provision and how these may change in response to policy initiatives and trends and innovations in professional practice. A qualitative service evaluation has been undertaken and has incorporated the perspectives of key professional groups in the Trusts along with key stakeholders’ views of representatives of senior NHS managers and service user and carers. As part of the initial phase of the project a systematic policy and literature review was undertaken to identify the key drivers of current and future mental health service provision. Base line information to support this relevant literature was also included from key Trust documents concerning provision and policies for present learning and development opportunities of staff (Jinks et al 2008). This is a report of the second phase of the project, which has obtained the views and perspectives of professional staff and key stakeholder NHS managers within the Trusts as well as service user and carer representatives on the current and future mental health services provision and learning and development needs.

Background

Central to the successful implementation of the National Health Service (NHS) Plan is the adequate and continuing preparation of its workforce (DH 2000). Since its implementation, and the subsequent publication of other significant policies driving the reform of Mental Health and Learning Disabilities Services (e.g. Sainsbury Centre for Mental Health (SCMH) 2001, DH/ Care Services Improvement Partnerships 2005, National Institute for Mental Health Excellence (NIMHE) 2005, DH 2004a, 2006), NHS Trusts are required to meet the ongoing challenges, introducing and continuing to develop the requisite changes in design and delivery of services for mental health services and the development of the workforce. An additional stimulus to overarching NHS modernisation has been provided through the Darzi quality review of the NHS with a focus on quality care for all (Darzi 2008).

Critically, the relocation of Mental Health Services from hospital to integrated community care provision, the growing involvement of service users and carers in design and delivery of services, and the increasing development of evidence-based interventions, have directly impacted on workforce learning and development needs (SCMH 2001, DH 2006). For example, increasingly varied service provision has been developed, where evidence-based effective care delivery now relies more heavily on a workforce that can engage with a wide range of agencies including primary care, housing and social services, as well as a range of specialist mental health and learning disabilities services. In addition, the review of Mental Health Nursing (DH 2006) acknowledges the implications of new roles for nurses (e.g. nurse consultant,
modern matron, nurse prescriber, the development of the advanced practitioner), and new ways of working for psychiatrists and psychologists (DH 2005). ‘Gateway workers’ (DH 2003a), ‘support, time and recovery’ workers (DH 2003b) and graduate primary health care workers (DH 2003c) are also initiatives that have learning and development implications for the workforce involved with mental health services provision.

To support the implementation of the National Service Framework for Adult Mental Health (DH 1999), the Capability Framework (SCMH 2001) was developed where levels of capability were identified for a range of professional disciplines such as nursing, occupational therapy, psychiatry, psychology, social work and professionally non-affiliated support workers in Adult Mental Health Services. The capability framework divided capability for modern mental health practice into five key areas that include, ethical practice, knowledge, process of care, interventions and context specific applications. These have been subdivided to identify specific capability statements. Although this framework relates to adult mental health services the underlying principles do provide a basis to assist service providers in identifying the workforce planning, learning and development needs across the whole workforce. The work of both Skills Councils for the health and social care sectors is also impacting on mental health services in terms of the current development of core, specialist and common competences for all non-medical staff in the workforce (Skills for Care 2009, Skills for Health 2009).

The above policies and their resulting organisational pressures all serve to reinforce the current political and socio-economic position faced by all NHS service providers and not least Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust. The imperative to sustain the ongoing changes required to achieve the modernisation agenda remains a constant challenge and one of the keys to its success is a competent workforce. It is essential that the workforce is appropriately prepared to meet the changes and future mental health services provision and that NHS Trusts’ learning and development policies and strategies are based on the best evidence available. This project has provided a review of key policy and literature on mental health services provision (Jinks et al 2008) and a workforce learning and development needs analysis, which is the focus of this report to inform the future workforce development strategies of both of these NHS Trusts.

Context

Mersey Care NHS Trust was established in 2001 and provides mental health and learning disability services for people of Liverpool, Sefton and Kirby. It also provides medium secure services for Cheshire and Merseyside and high secure services covering England and Wales. It has around 4,700 staff (around 4,000 whole time equivalent) providing services from more than 60 premises with an annual income of £190 million. The services provided include; adult mental health, older people’s mental health, learning disability, addiction, psychological, forensic psychiatry and high secure services and have been organised into clinical business units. The Trust has around 10,000 service users at any one time and will make contact with 200,000 people as
service users or carers throughout a year (Mersey Care NHS Trust Annual Report 2008). Learning and development opportunities for staff are organised and financed at corporate and service level.

5 Boroughs Partnership NHS Trust was established in 2002 and provides mental health and learning disability services to the people of Halton, Knowsley, St Helens, Warrington and Wigan. It also provides low secure services. It has around 2,100 staff (1,890 whole time equivalents) providing services from over 70 locations with an annual income of £97 million. The majority of staff are clinical (71%) most of whom are qualified nurses or health care assistants (60%; 36% band 5/6 qualified nurses and 24% band 3 health care assistants of total head count). The majority of staff are female in traditional associated roles although 50% of management staff are female (5 Boroughs Partnerships Board Papers 2009). The services provided include; children and young people, adult mental health, older people’s mental health, learning disability, and forensic which include 250,000 community contacts per year with service users or carers (5 Boroughs Partnership Annual Report 2008). Learning and development opportunities for staff are organised and financed at the Trust level from the Education Centre.
METHODS

Research Questions and Objectives

The research questions were:

- What are the trends and imperatives in mental health service provision and how do they impact on current and future learning and development needs of staff employed at Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust?

- What are Directorate managers and staff employed at Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust personal and occupational group perspectives of current and future learning and development needs of the workforce to meet the changes and services developments in mental health provision?

- What are representatives of service user and carers’ views on current and future learning and development needs of the workforce to meet services development in mental health service provision?

The objectives were to:

1. Establish what Directorate managers at Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trusts view as the main challenges to future service provision that will impact on future workforce learning and development needs to ensure a workforce that is able to meet any changes in service provision.

2. Investigate how the current learning and development opportunities meet the needs of the different occupational groups employed by the Trusts.

3. Identify what members of the different occupational groups view as their immediate and future learning and development needs.

4. Explore what Trust service user and carers representatives think are the main learning and development needs of staff in order to deliver effective services in the future.

5. Establish what learning and development opportunities need to be developed by the Trusts to meet the demands of the service for the next five years.

Design

The project design comprised evaluation research and involved iterative working of the team of University and NHS Trust staff and a service user representative. An evaluative framework using qualitative research methods was adopted as qualitative or interpretative research, with its roots in sociology, anthropology and philosophy, place the emphasis on the way people make sense of their subjective world and how they attach meaning to it (Polit et al 2001). Within the social context of the NHS, learning and development needs of the workforce exist and can be elicited from those employed and from the views of service users. There is an inextricable link
between those employed and the overall purpose of the organisation, which is not solely driven by its employees. It was therefore critical to establish individual employee and organisational need as well as taking wider stakeholder perceptions into consideration.

**Populations and Samples**

**Samples**

Each respective NHS partner on the project team took into consideration the project time frame and existing organisational structures and functions within their Trust and used this as the basis for identifying potential purposive samples. Key stakeholders from each Trust who were executive directors were identified for interview. Staff who participated in Learning and Development forums as part of the existing consultative arrangements were identified from each of the Trusts to participate in focus groups. Staff identified, were representative of the professional groups providing mental health services employed by the Trusts. Service user and carer representatives who provide user views as part of routine consultations to each of the Trusts were also identified to participate in service user and carer focus groups. Composition of the groups indicated that all the professional groups were represented on the forums and by virtue of being members of the group were committed to furthering and improving the educational opportunities for other staff members. Similarly members of the service user and carers’ forum are committed to improving service delivery of which increased educational opportunities for staff members are an integral part.

A potential sample of eight stakeholders who were executive directors responsible for strategic and overall management of each Trust was identified. A potential sample of 120 staff (60 in each Trust) and 24 service user or carers (12 in each Trust) were also identified and contacted to participate in 10 staff focus groups and two service user and carer focus groups (5 staff and 1 service user focus group per Trust). One Trust contacted staff that participated in their Learning and Development forums and members of the Service User and Carer forum while the other Trust widened potential involvement and sent out a general initial invitation to all staff via their intranet as well involving members of the Service User and Carer forum.

**Methods of Data Collection**

Data collection was undertaken from October 2008 to April 2009 once ethics approval had been obtained and took place within locations in each of the Trusts. Analysis and write-up was undertaken from May to August 2009. Project management and data collection were undertaken by University staff, and liaison, coordination and access for data collection within each Trust by the respective NHS staff on the team. Invitation letters, project information sheets and informed consent sheets were sent to each potential participant and their willingness to participate in the project was requested by returning a completed slip in a pre-paid envelope or via email prior to data collection.
Interviews

Semi-structured taped interviews that lasted up to 45 minutes were conducted with the key stakeholder directors and information was collected on their current role, title, qualifications, local and national policy for mental health services organisation and delivery, current provision of learning and development, skills required by staff for future provision of mental health services and challenges. (Figure 1).

Figure 1. Questions Included in Stakeholder Interviews

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your current title and role within the Trust?</td>
</tr>
<tr>
<td>2. Do you have any professional or academic qualifications, and if so</td>
</tr>
<tr>
<td>what are they?</td>
</tr>
<tr>
<td>3. What do you think are the key local and national policy drivers that</td>
</tr>
<tr>
<td>will affect mental health service provision in the next five years?</td>
</tr>
<tr>
<td>4. What effects do you think these drivers will have on the shape of</td>
</tr>
<tr>
<td>mental health services locally?</td>
</tr>
<tr>
<td>5. What is your assessment of the effectiveness of current education</td>
</tr>
<tr>
<td>and training provision that the Trust provides?</td>
</tr>
<tr>
<td>6. Are there any current gaps in educational and training provision</td>
</tr>
<tr>
<td>locally?</td>
</tr>
<tr>
<td>7. What skills do you think staff will need to deliver new models of</td>
</tr>
<tr>
<td>mental health service provision?</td>
</tr>
<tr>
<td>8. Are there any constraints or challenges that need to be considered</td>
</tr>
<tr>
<td>when considering what future learning and development needs?</td>
</tr>
</tbody>
</table>

Focus Groups

A series of 12 focus groups were held between January and April 2009 (5 staff groups and 1 service user and carer group for each Trust) and lasted around an hour per group and took place at Trust locations. Staff groups were a mix of inter-disciplinary or uni-disciplinary. Participants were drawn from the professional groups employed at the Trusts including, nurses, psychiatrists, occupational therapists, social workers, clinical psychologists, administrative and clerical staff. Service users and carers were recruited from the Trusts’ Service User and Carer meetings and their expenses were met and an honorarium available as part of Trust policy.

Two members of the University project team, acted as lead facilitator (LF) or note taker at each focus group. The institutional independence of the lead facilitator (not being affiliated with any higher education institution or NHS
trust) for the staff focus groups enhanced the validity and the reliability of the process of data collection (Krueger and Casey 2000, Wall 2001). There are recognised limitations to the use of focus groups such as when more vocal members take over the discussions. Similarly the ‘Peacock’ effect, which is when males or those in high status positions try to dominate, may also be a problem (Jinks & Daniels 1999). However, such difficulties can be circumvented when experienced facilitators undertake the focus group discussions, as was the case in this study. The focus groups were taped recorded and adhered to recognised good practice (Morgan 1993, Silverman 1993, Cresswell 1998).

Prior to data collection informed consent was obtained from all participants. Semi-structured guides were used for both sets of focus groups (Figures 2 and 3). Before the focus groups for staff were conducted they also completed an anonymous semi-structured questionnaire that requested information on their job title, location of work, academic and professional qualifications and any organised educational activities they had attended in the previous 12 months.

**Figure 2. Questions Used in the Staff Focus Groups**

1. What is your understanding of how services are going to evolve over the next five to ten years?

2. What skills do you think you will need in order to deliver these services?

3. How would you prefer to engage in the education/training evolving in order to meet your needs?

**Figure 3. Questions Used in the Service User and Carer Focus Groups**

1. What skills would you like staff to have?

2. How can we improve the care that a service user would receive?

3. How do you think services should be developed over the next five to ten years?

4. What skills and learning development do you think staff will need in order to deliver these services?

5. From your role in this forum, what do you think are your skills and learning development needs?
At the end of the interviews and focus groups participants were thanked for their involvement and asked to add any additional information they wished to.

**Ethical Considerations**

Ethics approval for the project was obtained via the National Research Ethics Service from Sefton Research Ethics Committee prior to commencement of data collection. Research Governance complied with existing procedures of the Evidence-based Practice Research Centre, Edge Hill University and those of each of the Trusts’ R&D Committees as required by the NHS.

Written informed consent was obtained prior to data collection and ensured that participation in the study was voluntary, and assurance given that data were confidential and identities anonymous. Written informed consent was also obtained for the use of any direct quotes. Data have been stored on a password-protected computer with only members of the research team having access. Hard copies of data will be stored in a locked cupboard for three years after completion of the study and electronic data for 10 years as required by NHS research governance.

**Data Management and Analysis**

Data from the staff focus groups relating to participants’ job titles, locations of work, academic and professional qualifications and any organised educational activities they had attended in the previous 12 months were collated and reported as frequencies. Tapes of interviews and focus groups were transcribed and thematic content analysis of the qualitative data performed to identify key themes and sub-themes using the initial questions as an analytical framework (Denzin & Lincoln 1998, Krippendorf 2004). A minimum of two members of the project team undertook the thematic content analysis to identify the themes. These themes were discussed and agreed by three members of the project team and saturation of the data agreed. The themes identified relate to both interviews and focus groups.

**Reliability and Validity**

Initial interviews and focus groups constituted pilot work to establish the feasibility of sample recruitment and test the methods of data collection. No changes were required to the interview schedules or focus group schedules. Validity was assured during the interviews and focus groups by ensuring lines of inquiry verified the accuracy and consistency of responses. Members of the project team were experienced in data collection methods and analysis, which also contributed to both reliability and validity. Reliability of the analysis was further assured by independent reading of the interview and focus group transcripts followed by discussion and agreement of the themes and sub-themes until saturation was obtained. The non-NHS institutional affiliation of the focus group facilitators and stakeholder interviewer added to the validity and reliability of the analysis and the interpretation of findings (Krueger and Casey 2000, Wall 2001).
FINDINGS

The findings include information on participants that took part in the interviews and focus groups (respondents) and key themes and sub-themes identified.

Participants

Of the eight stakeholders interviewed, all held leadership positions within the Trusts with six directors (medical director, nursing director, human resources, or service user and carers), one assistant chief executive and one non-executive director. All except one had professional qualifications that related to medicine, psychiatry, general nursing, mental health nursing, speech and language therapy, management or personnel and development. All held a range of academic qualifications with all but two having graduate and postgraduate qualifications and two having PhD degrees. All but one had been employed within the Trust from between 1 year to 10 years, with one holding their current position for five months but having previously been a Director of Nursing in another Mental Health Trust and two being appointed into their current roles for seven months but employed within the Trust for longer.

A total of 64 respondents participated in the focus groups (50 staff and 14 service users or carers) giving an overall response rate of 47%. Individual response rates are provided in Table 1. Due to the different approaches to recruitment and invitation to participate in the focus groups a comparison of between Trust response rates is not realistic although individuals expressing an interest did appear to maximise participation.

Table 1. Response Rates for Focus Groups According to Trust

<table>
<thead>
<tr>
<th>Focus Groups</th>
<th>MC</th>
<th>5 BP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numbers Invited</td>
<td>Numbers Attended</td>
</tr>
<tr>
<td>1</td>
<td>35</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>12 *</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>97</td>
<td>36</td>
</tr>
</tbody>
</table>

Key = MC = Mersey Care NHS Trust; 5BP = 5 Borough Partnerships NHS Trust; * = Service User and Carer Focus Groups
All clinical areas were represented in the staff focus groups with the majority of participants coming from High Secure or Forensic Services, Elderly Adult Services and Acute Adult Services (Table 2). Participants came from a range of clinical, managerial or administrative roles providing a range of staff from each Trust with the highest proportions holding nursing, non-professional or operational management roles (Table 2). Most participants in the focus groups held nursing qualifications and were graduates (Table 3).

**Table 2. Participants in Focus Groups Clinical Area and Role According to Trust**

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>MC n=28</th>
<th>5BP n=22</th>
<th>Total n=50 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Adult Services</td>
<td>7</td>
<td>2</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>Elderly Adult Services</td>
<td>7</td>
<td>3</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>CAMHS</td>
<td>2</td>
<td>2</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Learning Disabilities (Adult)</td>
<td>2</td>
<td>2</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Community Services</td>
<td>5</td>
<td>5</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Forensic/High Secure</td>
<td>10</td>
<td>10</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>1</td>
<td>1</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>8</td>
<td>11 (22%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>1</td>
<td>1</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>1</td>
<td>4</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>7</td>
<td>4</td>
<td>11 (22%)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
<td>1</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>2</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Non-professional</td>
<td>2</td>
<td>9</td>
<td>11 (22%)</td>
</tr>
<tr>
<td>Operational Manager</td>
<td>8</td>
<td>2</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>1</td>
<td>9 (18%)</td>
</tr>
</tbody>
</table>

Key: MC = Mersey Care NHS Trust; 5BP = 5 Borough Partnerships NHS Trust; CAMHS = Children & Adolescent Mental Health Services
Table 3. Participants in Focus Groups Professional and Academic Qualifications According to Trust

<table>
<thead>
<tr>
<th></th>
<th>MC n=28</th>
<th>5BP n=22</th>
<th>Total n=50</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional Qualifications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>1</td>
<td>1</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Medicine/Psychiatry</td>
<td>1</td>
<td>4</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Nursing</td>
<td>15</td>
<td>5</td>
<td>20 (40%)</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>1</td>
<td>1</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>3</td>
<td>3</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Social work</td>
<td>3</td>
<td>3</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
<td>5 (10%)</td>
</tr>
<tr>
<td><strong>No Professional Qualifications</strong></td>
<td>3</td>
<td>9</td>
<td>12 (24%)</td>
</tr>
<tr>
<td><strong>Academic Qualifications</strong> *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhD</td>
<td>1</td>
<td>1</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Masters degree</td>
<td>7</td>
<td>2</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>Postgraduate diploma</td>
<td>3</td>
<td>7</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>Undergraduate degree</td>
<td>11</td>
<td>9</td>
<td>20 (40%)</td>
</tr>
<tr>
<td>Diploma Higher Education</td>
<td>5</td>
<td>3</td>
<td>8 (16%)</td>
</tr>
<tr>
<td>Certificate in Education</td>
<td>3</td>
<td>2</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>3</td>
<td>9 (18%)</td>
</tr>
</tbody>
</table>

Key: MC = Mersey Care NHS Trust; 5BP = 5 Borough Partnerships NHS Trust; PhD = Doctor of Philosophy; * = % Do not add up to 100% as can hold more than one academic qualification

Key Findings

The key findings from the thematic content analysis from the interviews and focus groups are detailed using exemplar excerpts of verbatim data to illustrate each theme. Three main themes include: policy and organisational drivers, learning and development needs, and challenges and opportunities for future mental health services. The identity of each Trust is concealed with reference only made to ‘Trust’ or ‘organisation’. Likewise, directors, staff groups and service users are referred to as ‘respondents’.
Policy and Organisational Drivers

Figure 4 presents the range of national and local policy and organisational drivers cited by respondents effecting future mental health service provision in the next five to ten years.

**Figure 4** List of National and Local Policy and Organisational Drivers Identified by Respondents (alphabetical order)

- Advocacy
- Appleby Review
- Boyington Report (NHS NW 2008)
- Bradley Report (The Bradley Report 2009)
- Case management
- Dementia Strategy (DH 2009)
- Darzi Review (Darzi 2008)
- Eating disorders
- E-care
- Faster access
- General practitioner care
- Human Rights approach including respect, equity, dignity, and autonomy of service users and carers
- Increasing numbers of clients with a decrease in public finances
- Integrated Care
- Interface with criminal justice system
- Less inpatient capacity
- Mental health capacity
- Modernisation agenda
- Multi-site development opportunities
- National Service Framework Mental Health (DH 1999)
- Offender prison health agenda
- Pathways to accessing treatment
- Personal budgets
- Personalised care
- Prevention of mental ill health
- Provision of psychological therapies
- Recovery Models and Outcomes
- Secure provision
- Service User and Carer Involvement
- Social inclusion
- Stepped care
- Public health agenda
- Quality driving down costs
- User led assessment
- Valuing People
- Young people’s psychological well being
- Whole systems approach to mental illness and mental health and well being
Learning and Development Needs

Figure 5 lists the specific learning and development needs and challenges identified by respondents, which could be used as the basis for the development and content of future learning and development strategies for each Trust.

**Figure 5. Learning and Development Needs/Challenges (all respondents)**

- Remuneration of service user involvement
- Infrastructure to underpin service user involvement
- Collaborative involvement of service users/carers in curriculum development/delivery
- Knowledge and understanding of recovery
- Reflection on practice in forensic services
- Personal boundaries
- Forensic sciences
- Criminal justice system
- Psychology of offending
- Managing the care needs of offender populations
- Interpersonal boundary work
- Autism
- Asperger’s syndrome
- Negotiating skills in primary care and general practice
- Dementia care
- Acute liaison work
- Online learning
- Business management principles

All respondents whether stakeholders, staff or service users and carers recognised the complexity and diverse range of agendas that need to be considered and taken forward by their organisations. They appreciated this would involve differing structures and ‘doing things differently’ with more focus on mental health and well being in communities and integrated care. Consequently there were both challenges and opportunities that would impact on learning and development needs. The thematic content is described below using representative excerpts of verbatim data to illustrate each thematic category drawn from the ten staff focus groups (SFG 1-10), two service user and carer focus groups (SUCFG1-2) and eight stakeholder interviews. The following key themes were identified across all respondents (directors; staff groups; service users/carers)(Figure 6).
Modernisation

The theme of modernisation emerged from all respondents each of which articulated particular viewpoints. For example, service users and carers articulated concerns about the type of service required in relation to user needs, for example:

“..if I ever get admitted again, I want a service that is going to work for me. The service that I want: something that’s got more things to do on the ward; more therapies; more activities; something that doesn’t let my brain go stagnant and make me feel more mentally ill..so there’s always challenges I think for
everyone when they have an illness; it's about maintaining this level and feeling good about yourself I think.” (Respondent, SUCFG1)

One service user’s articulation resonated with aspects of the above when summarising their own desires for the service:

“Less psychiatry and more psychology.” (Respondent, SUCFG1)

In addition, ideas for service (re-)design were articulated; for example:

“I’d like to see a new family service for all the people that are affected, not, you know, when somebody becomes ill...there’s a lot of grief left behind within the family which needs to be solved. But it needs to be solved by somebody other than the person that’s dealing with the patient. You need to give people an opportunity to explore what’s happened within the family, how it’s affected different members and what the support needs particularly with reference to children and I think a lot could be done for example in the six, seven week summer holidays for kids with a little bit of support through the education systems which are already there. It’s not that we have to set up something all new that’s going to cost a fortune, the thing is already there within every education service...You could provide structured activities for young people and children with your junior trainee psychologists, educationalists...to give them a general background. then you will begin to do a lot more so that when the person is being treated..and they’re then returning (if that’s what’s going to happen) to the family, there’ll be a lot more of a cushion because people will have a lot, the people within the family, will feel more comfortable about what’s happened.” (Respondent, SUCFG1).

Some focus group respondents articulated a view of service deficiencies and what users want. For example:

“There’s a lot of service user frustration and disappointment in kind of the limits really of the medical approach in helping people with psychosocial difficulties. And that’s not you know necessarily the fault of the medical approach. It does its best... But nevertheless I hear enough complaints from service users about a lack of time; a lack of talking therapies; huge waiting lists for talking therapies. And I just think that there’s going to be much more demand and expectation for time to talk, you know, talking therapies, skills based groups and less of this kind of almost containment, you know, of long-term chronic patients-review kind of based, risk focused interventions. *People want more than that.*” (Respondent, SFG6, emphasis added).
The above view was also reflected in another way in terms of striking a balance between episodic and longer-term rehabilitative interventions. For example, this knowledge emerged from the following interaction between two focus group respondents:

Respondent 2: 

"..care planning, you know training, rehabilitation programmes. And we're not encouraged to do that. We're encouraged to do the one to one therapy and it's something about, there's something about the assumption, it's almost like the primary care model of people with moderate, mild difficulties is wrongly applied to us in secondary care. It's like well ten [to] twenty sessions of CBT will fix this person but actually that mindset and model does not fit and the kind of psychiatric model doesn't always fit. They kind of medicate and sedate away people's distress. They need more long term skill development and rehabilitation and we're not that good at that really and we need much more of a rehabilitation mindset and skill development and how do you help people with long term trauma, untreated trauma. And that's the other frustration that I hear what you're saying that like we see people who've been in the system for donkeys years and they've just had a purely medical containing approach, kind of reviews, encouragement, support but no psychological therapies for example and we get that all the time don't we, we meet people years and years and years along the line who have become chronic career patients. Now we want to get away from that obviously....."

Respondent 1: 

".. absolutely"

(Respondents, SFG 6, emphasis added).

The perspectives of service users and carers regarding episodic treatment may be different to the perspective of staff. For example, the following account may call into question the legitimacy of short term therapy for this particular individual:

"And after your six weeks its bye, ok you're alright now; no because you've had no feedback, you've had nothing. And it might work for a minority but anybody I've spoken to.. and I think it's just your GPs way of getting you away from his desk. Counselling, there's the answer. And it doesn't answer your problems, because you're still churned up inside and you can't go and see a stranger for six sessions and open your heart to them. You just can't do it. Not if you're not getting any feedback." (Respondent, SUCFG1).

This approach was also reflected by other focus group respondents working directly with service users in the community in order to help build their psychosocial capabilities. For example:

Respondent 1: "I do think there seems to be more of a focus now on you know getting people involved in sort of social,
meaningful social activities rather than just medication. That’s a big part of my role. I take quite a few service users to different gyms in the borough that I work in, you know support them with that. Get them motivated and working towards them going independently. Other service users I take playing five a side football in groups. Others I go bowling with.”

LF: “And is this a new sort of role?”
Respondent 1: “Yeah, I think it is anyway”
Respondent 2: “I think it’s about letting them know that there’s more to life than sitting at home and taking a pill every day, getting them back to some sort of form of routine.” (SFG 7)

Furthermore, this renewed social focus also was evident in parts of the services where the perception was of there being a less easy balance struck between notions of containment and (re)habilitation. For example:

“..we’ve just done some work over the last year and identified that there’s a need for a step down ward which is different to a pre-discharge ward, which we have at the moment, but looks at preparing people for transfer to other facilities, or back into the community..we’ve identified that certainly from the service model that the social component of treatment, rehabilitation, management or (not even rehabilitation but) habilitation - because lots of them come from impoverished backgrounds and go back to impoverished existences - we’ve identified there’s a need certainly to be more inclusive of a social component in in-patient services and I suppose rather than being a treatment modality it’s more an inclusive approach around those needs. I mean we’ve had discussion about that haven’t we in terms of how that would look. (Respondent, SFG9, emphasis added).

In relation to the personalisation agenda, staff focus group respondents’ awareness of the change towards partnership working was set against real world constraints.

For service users, an individual focus is seen as paramount:

“..every client requires an individual relationship there isn’t a one method will fit all model and it’s down to the skill of the particular employee as to how they first initiate that reaction in the client and then manage the onward progression and support because you know we don’t always progress forward sometimes we take two steps but from that point on every individual requires an individual relationship.” (Respondent, SUCFG1 emphasis added).

For some respondents the earlier shift towards using psychosocial interventions in mental health services alongside other forms of intervention has helped create a positive context for implementation of the personalisation agenda.
Crucially, the personalisation agenda was found to be strongly promoted by those working very directly in the community setting whose objective is to focus on the individual and their needs, using a non-stigmatizing and non-pathological approach. For example, this knowledge emerged from the following interaction between a focus group respondent and the lead facilitator (LF), which also indicates these respondents’ levels of competence and skill, concerning which they are both modest and self-effacing:

Respondent 1: "You’re looking to you know help people as an individual, you don’t you know not just everyone (is) the same come on we’ll go for a cup of tea at Tesco and everything will be all right, you know. You’re looking for something you can put into place that that person will engage with and stick with long term, you know.”
LF: "And how do you do that?"
Respondent 1: "Well you’ve got to get to know them haven’t you and know what they want."
Respondent 2: "I don’t particularly do anything, not nearly as much as what [colleague’s name] does because like I say we’re at the crisis stage so we spend most of the time in the client’s home. But again you’re choosing your initiative and you can get certain individuals that you know they won’t speak to you or it’s very, very difficult to get them to speak. So again it’s just looking around the house and seeing their family photographs or they might have a painting on the wall and, or certain things about you know, would you like reading such and such a book, or you know, if there’s a pile of DVDs or just something to you know break the ice and, and just sort of to get them to open up and start chatting and then you get to the you know what would you like to be doing and what do you feel that we can do for you and you know as a team...”(Respondent, SFG 7, emphasis added).

Integration of care was reported in relation to the perception of the increasing number and complexity of co-existing diagnostic problems like drug use, alcohol use, personality problems, self harm; all of which were seen as increasing dramatically and involving particular learning needs. For example in relation to the physical health care needs of service users and what this implies for staff competences:

“As the complexity of the clients are changing, we’re seeing a lot more people coming through with more acute physical health care needs.. but it’s how our staff have got the skills to manage that and maintain their needs really when they come in as an in-patient and we’ve got a big gap in, in service provision there at the moment because we’ve seen that..staff have got some basic skills and a basic underpinning knowledge of physical health care issues but some of the things that we see..people coming through with..they’ve got pacemakers, they’ve got blood
pressure machines, and things like that. What we haven't got are those level of skills to be able to manage that person more acutely ill person on a ward environment.” (Respondent, SFG1, emphasis added).

However, from the perspective of service users/carers, the focus on the psychiatric diagnostic label may skew the clinical focus of the attending physician. Service users’ accounts show more pressing care needs may be overlooked whilst greater attention is paid to their psychiatric diagnosis as opposed to physical health needs:

“..but because there’s like a label then somehow the rest of it.. and I’ll give you an example. It was last year..I went off to see my GP and I’d been on repeat meds for a few years..and all the rest of it...I rolled up yet again and sat down and he was on his computer screen and typing away and I’m sat there and..he’s going through all these [questions] Am I suicidal? Am I still taking this medication? Blah de blah de blah. So a few minutes of this and he’s a nice GP, you know quite like him, or whatever, but he was there and he got to the end and he sits back and says: So what can I do for you? I said well actually my finger has got infected, I don’t know how and I was going to go to the drop in, I’ve just phoned and actually I could get in so, access not a problem whatever, and I do feel an idiot but actually it’s getting really bad. I don’t know how it’s happened, I must have banged it or whatever, the two fingers and, and it’s really, it’s getting all pussy and whatever. Oh no, no right you know. And there was an example that I’d rolled umpteen times over the years and I was on all these whatever you have on the screens and the physical side. Yeah he could have had a few ECGs, oh it’s stress or whatever, give up all the stuff you’re doing, which is that, you know whatever. And, and so because of the label and whatever I think we forget..they’re somehow going to ignore you, it’s the attitude that’s wrong or whatever..” (Respondent, SUCFG1)

In order to deliver new physical assessment competences in practice, both organisations appear to rely on their local higher education providers (HEIs) or deliver this training in-house. For example:

“I think the only concern is some of the skills we would be looking at regarding that and signing people off, we probably would struggle with having that level of competence around those areas in practice to be able to do that. So we’d need the support from the higher education institutions around sort of that advanced practice arena to be able to develop our competence..in practice. Does that make sense?” (Respondent, SFG4, emphasis added).
The impact of other national policy frameworks like the National Service Framework for Mental Health (DH 1999) emerged in relation to respondents’ understanding of the development of newer mental health services like crisis resolution, home treatment and early intervention.

Standards were seen as taking time to embed due to organisational size and some services like Older People’s Services were seen as lacking local driving forces in the face of a National Dementia Strategy (DH 2009). Concerns were voiced about not moving forward enough around the Mental Health Act, due to lack of appropriate guidance leading to cautious practice. The management of suicide risk was offered as an example of the above cautious practice where practitioners may be tempted to become more focused on ticking the risk assessment boxes to meet the performance indicators rather before thinking about the needs of individual patients.

**Quality, outcomes and business principles**

The implications of not being able to develop and provide evidence of quality, efficiency and effectiveness (all principles of Darzi (2008)), were demonstrated:

“...If you’re going in[to] a tender situation you would hope that our winning sort of thing would be the quality. But we haven’t got that quality matrix in there to say well although you’re cheaper, hey guys if you come here your recovery time will be shorter, your time in hospital will be better, you’ll get a community nurse...we can’t do that at the moment and I think that’s a huge, you know, workforce issue. “ (Respondent, SFG4, emphasis added).

Furthermore, instilling the principles of quality, efficiency and effectiveness was seen as the remit of the organisations, the universities and of each staff member individually:

“It’s something that should be encouraged and embedded within the workforce as they’re employed but I think it also should be involved and brought up and covered within the continuing curriculum. You know you want to develop this [initiative] on your ward well, what’s going to be the impact? What’s that going to look like? Teaching them. Simple.. You know if you had an outbreak of salmonella, what would be the impact? You know..(Respondent, SFG 9, emphasis added).

Services were seen as becoming more outcome driven in the sense of there being a greater focus on the consequences of care received, as opposed to the process of processing patients through a mental health system. For example:

“..we need to be skilled in not developing but demonstrating outcomes. And measuring them, you know, so sharing that with
the service user but you know not just professional outcomes, because sometimes they’re just technical tick boxes, they make no sense to the individual who’s got the problem, but it makes sense to us and we can demonstrate to somebody, oh look this is what’s happened. But someway of making some meaningful outcomes, you know.” (Respondent, SFG 2 emphasis added).

Respondents demonstrated the need to provide good quality experience for service users and to be able to deliver the contracted activity to commissioning requirements; as the special commissioners are now seen as the “pay masters” due to payment by results. For example:

“Providing good quality experience that the service users want and being able to produce the activity and the numbers that meets the requirements of our commit[ments], our special commissioners, the pay masters basically, because it’s very, very much going to be very focused on payment by results.” (Respondent, SFG9).

Market competition, service reviews and the need to continually reconfigure or at least challenge the need for existing services if required, were well understood and perceived across many staff groups.

There was no doubt that a new service identity is now being assembled, and one in which many respondents appeared actively involved in helping to create and shape; but simultaneously questioning whether clinicians get the opportunity to truly market their own services:

“I think it’s going to be a competitive market and I just think we need to be very aware of what we’re offering, what we do better than anybody else, how we market it, and we can only do that based on performance and benchmarking. I’m not convinced, as clinicians, we get the chance to really tell the people who can market that for us at a commissioning level.” (Respondent, SFG 6 emphasis added)

“I mean at the end of the day if we become a Foundation Trust we’ll be a bit like a business in that where you have standard business thinking [which] is you have to grow your own employees and skill them up. We’ll have to. And I think from Board level there’ll be a responsibility and a push.” (Respondent, SFG 10)

Whilst a greater engagement with market (business) principles was seen as inevitable, it also seen as potentially problematic:

“once you get to [being a] Foundation Trust it’s we don’t talk to anybody else because we don’t want them to know our secrets isn’t it, because it isn’t it you’re in a competitive market so it closes a lot of doors that currently might have a little bit of a, a
chink of light through them they will become very much more closed shops and that could have an issue in itself." (Respondent, SFG4)

The perceived learning need to improve knowledge of marketing was addressed for some respondents by the local universities.

Furthermore, learning themes were identified in relation to the new development of quality initiatives, the renewed focus on outcomes and the organisations’ implementation of business principles. For example:

“Currently it is about marketing. I was just discussing making a pitch, that’s what we’re going to get training on. *How to pull tenders together*, those kinds of things that wouldn’t come naturally to us, if you like. And there is a heavy focus as well on *leadership and improving your leadership skills* and, as I say, there have been some training supplied from the Trust and...there’s *creativity workshops* there’s a big push on. *How to be more creative and innovative and how you have the space to do that*. So we have to find you know some mechanism for *being more creative and certainly we’re getting online financial training* as we speak to be able to understand budgeting and so forth more than we do now.” (Respondent, SFG7, emphasis added).

The above acknowledgment over creativity shows how current jobs are not designed to optimise creativity, as staffs need to be ‘trained’ to see how they can become innovative rather than developing or practicing these skills from within their role.

**Power of commissioning**

The theme of power of commissioning emerged in relation to shared perceptions over the inability to provide evidence of quality or contract volume that would inevitably lead to a loss of contracts, and possibly decommissioning and re-commissioning of the trusts’ services from their competitors. Within this developing context services, jobs and/or roles are increasingly becoming seen as vulnerable or potentially transient but, reportedly, not by all. For example:

“..there’s the bigger group of staff that still have that, this is a job for life and why should we change, we’ve always done it like this so you just took...so there’s, that’s a skill in itself getting those staff onboard and getting them to recognise that you know, know things are changing and this isn’t a job for life and we’re all being held accountable and we’ve all got to demonstrate that we’re doing our best and we’re improving and constantly changing...” (Respondent, SFG4)
Respondents also articulated the problems experienced trying to identify new ways of learning (and thinking about learning) in order to underpin service developments whilst simultaneously experiencing uncertainty around the ultimate effects of organisational change, and future commissioning plans, and the latter’s impact on jobs and job security. For example:

“..[concerning] a lot of the services that we currently provide for diagnosis and early stages of dementia, they’re [the PCT commissioners are] saying [they] should sit probably in Primary Care which then means that it’s lost to us. So that’s a big chunk of the Older Peoples business that’s lost to someone else...So there’s an incredible amount of uncertainty for everyone working within the system...we don’t even know in six months time whether potentially anyone in this room, what role they will have; if they will have a role in six months time, when the [organizational change] come[s] into existence...So there’s uncertainty and despite what you say to clinicians, supposedly, the word is that they will not be affected, it’s more the management structures. But they can’t help but feel affected and frightened and their job insecurity is quite real to them despite what we might tell them – it [redundancy]’s not going to happen - they see it as a possibility and so to get people learning and thinking about ways of moving forward, I think right at this time is very, very difficult.” (Respondent, SFG1, emphasis added).

**Commissioning learning and development**

The theme of commissioning learning and development emerged in relation to the need for more transparency around what learning programmes the organisations want from the local education providers, and the particular processes governing how such needs are identified and addressed through the education commissioning and contracting processes. For example:

“There is the learning and development agreement [that] gets signed and what [a deputy director] puts out to all the managers, service managers, the need to help the staff. Rather than just ask the NHS Northwest to put on you know so many courses under the Post Qualification Framework (PQF), we’ve now turned around and asked you know what are the [development] needs of the staff?.. And we try and then ask the universities can they provide these courses under the PQF, which sort of fits more of the needs.” (Respondent, SFG5, emphasis added).

Problems with accessing the PQF were reported by addiction services due to perceptions over their location inside mental health services; as well as accessing PQF modules that are too generic for the purposes of the organisations. The Physical Health Care PQF module procured for Older People’s Services was reported to have had a large positive influence on service delivery.
The learning and development agenda was seen by some respondents as a difficult and perpetual debate for the organisations. This view resonated with particular knowledge deficits that respondents felt were omitted. Overall there was a limited understanding from respondents about exactly how learning programmes are commissioned, and the stake each NHS organisation has in this whole process. In-house programmes were reportedly developed to meet organisational learning and development needs. For example, in relation to forensic knowledge and other domains of psychiatric knowledge:

“[but] where would you send nurses to do training in boundary work and work on personality disorder. We’ve ended up generating this stuff ourselves anyway for you know, for it was a distinguished a distinct personality disorder care pathway in some of the..wards we are involved in it. For example, we’ve [had a] major initiative for a couple of years where we basically brought people up to what would be university certificate level in working with personality disorder and we put the stuff together ourselves. “ (Respondent, SFG5).

Furthermore, difficulties were reported with accrediting these types of learning programmes through some local HEIs. A positive role for further education providers was reported for staff development after undertaking National Vocational Qualification (NVQ) around literacy and numeracy. A much closer and flexible link with the HEIs “coming into the organisations” was seen as helpful for several reasons:

“There’s also something about the HEIs coming in to us as well, so .. because we’re all starting to think now about PQF modules..The bids were put in November in actual fact we could do with getting that back now and ripping it up and starting again because of the different drivers that we’ve spoken about. So there’s something about regular actual face to face contact with the HEI providers to say actually these are the things that are missing and instead of you doing it, you know, session number eight, we’d like that, take away that theoretical bit, and do practical: it needs to be more flexible?” (Respondent, SFG1, emphasis added).

Further discussion revealed that this ‘coming into’ was defined as having strategic links into the organisation at senior level. The commissioning of learning and development to meet service needs and not individuals’ needs was seen as paramount. Building learning and development into staff roles was seen as possibly a more focused approach, rather than what was termed the current “scatter gun” process of relying on anecdotal accounts of required learning and development often without any strategic overview, or corporate plan, that is, without any evidence for commissioning these developments.
The multiplicity of stakeholders

The theme of multiple stakeholders emerged in relation to the increased involvement of service users/patients and their representatives; all of which were seen as a positive driver for future service provision and the development of new approaches to care and treatment. Respondents saw this future as being defined by user self care, users’ developing their own care plans, undertaking their own needs assessments and service planning:

“Rather than them doing what the PCT has decided they want a service for, to actually go out and tell the PCT this is the service you should be funding and I’d like to see users and carers getting involved in planning the service we would like and then go and sell that service to get the funding for it. Not the other way about.” (Respondent, SUCFG1).

In addition, respondents viewed the best learning and development activity as that which jointly included service users and their carers as teachers and/or peer recipients of professionals. There was evidence of initiatives in each organisation for involving professionals and service users/carers in learning and development activities as well as on employment interview panels. All of these changes were seen to need significant effort, a change in professional culture from paternalism to enablement and empowerment, with the health sector lagging behind such developments in social care:

“Staff are not geared up for that because staff see themselves as ‘We’re here to do the assessment’, ‘We’re here to listen to your needs and tell you what your needs and here are the resources I’ve got’. We’re moving to where somebody rings up and you say right well here, here’s the assessment form, you write down your needs and I can be creative with the resources. We are nowhere near ready for staff to be able to that but in a social care arena they are doing that. You ring up social services and they’ll post you out a self-assessment and you send it back, they’ll look at it and allocate resources to you and health is moving in the same, similar direction.” (Respondent, SFG1, emphasis added).

This changing service focus resulting from trying to embed recent policy was seen as influencing a cultural change within NHS providers. For example:

“But really the shift is around enablement, around recovery, and I think staff need to be able to almost like take a step back and know when it’s their turn to give, you know like advice on medication or monitor a process of going through benefits, you know, I think. But it’s also a time to know [when] to enable somebody. There’s a different approach required and it’s about tapping into what’s out there. It’s about tapping into the individual skills, family networks and to be able to say to staff that assessment is key to be able to write up, you know,
recovery plans is the key. But actually doing it all is changing, that’s my personal view. I think if I was a nurse now on, on the road, my approach would be different, using very similar skills, assessment care planning, risk management.” (Respondent, SFG8, emphasis added).

The embracement of enablement or recovery concepts were seen by some respondents as problematic in that different definitions of recovery exist and moves towards shorter and more discrete interventions may not suit all service user and carer needs. For example, the following two respondents deliberate on the issues and fact over the existence of different definitions and perspectives between staff/service users as well as the equal need for long-term management:

Respondent 2:” And I suppose the big driver in terms of mental health has been much, my surprise, is around recovery ..and it’s basically it’s open season..everything from definition to you know all the various elements were kind of open to debate and I suppose really ultimately it’s a case of the Trust..aspiring to be recovery focused. The question is what does that mean?.I keep having plenty of debates as to what recovery means because recovery to staff and organisations is they’ve got their own ideas. And recovery from our perspective there’s a bit of a mismatch at the moment and so I just wonder whether maybe that’s something...

Respondent 1:”Well recovery is really important but for some people. Where that’s not possible but management is, and I think managing a condition if you’re living with it long term, I think that’s just as important. It shouldn’t be getting your complete, some people will never be fully recovered, they might need medication but it’s controllable and I think management is just as important as recovery as a focus.” (Respondents, SUCFG2, emphasis added).

Other staff respondents echoed that there was a balance to be struck between episodic and maintenance types of intervention. For example:

“I think that’s part of the risk underpinning risk culture, isn’t it that we’re being pushed to the episodic all the time and just do very short, discreet episodes of care. But for people in fact staying involved in their lives in some way maintains them to be as well as they can be.” (Respondent, SFG6).

A more fundamental point was articulated about the rhetoric of recovery and the need for consistency between the rhetoric of policy and operational delivery:

“But equally it’s something around what messages Trusts and the government give. I’m tongue in cheek but actually come to use it a few times now I say, we’ve talked about the Department
of Health guidelines you know, all these things you mentioned away from the medical model to that wider integrated recovery, whatever.... whatever. Yet here’s a Trust, they’ve all got them, a Medical Director, we don’t have a Director for Recovery, yeah.” (Respondent, SUCFG2, emphasis added).

Some respondents pictured a shift in dealing with the dependency previously created by professional services, which through partnership working, could change at a mutually satisfactory pace. For example:

“...where by people can do it because it’s all well and good talking about recovery and it’s all well and good saying to people you’ve got the skills within you but if that person has got that dependency on services we need to do an awful lot of work around removing that dependency in the first instance I think.” (Respondent, SFG8, emphasis added).

The therapies were reportedly better at embracing the recovery model and its associated expectations in the sense that respondents understood that users may be seen by those professions as having a potential to recover, albeit, in a limited way for some with longer term conditions. Some respondents reported the need for acknowledging that psychosis or, severe personality difficulties, requires support, so signalling non-recovery. Better operational definitions of the concept of recovery were requested yet were also seen as difficult given the public push for “fixing people” via “talking therapies” like cognitive behavioural therapy. The latter emerged in context of a general move away from rigid frameworks that treat people as psychiatric pathologies (‘schizophrenics’ etc) towards an approach that involves understanding abstract/complex information and transmitting it in a meaningful way for care planning and service users. This was seen to require translation and understanding of information in order to make something more intelligible and less traditionally pathological for service users and staff. Similarly service users/carers had a nuanced understanding of the issues surrounding the implementation of a recovery model. For example, the following knowledge emerged from the interaction between three service users/carers:

Respondent3: "....you’re giving false hope to people when you say about recovery because especially if you’ve got somebody who’s got a severe enduring mental illness such as schizophrenia or bipolar or whatever you know, unfortunately they’re going to have to be maintained on medication and..they need to have some hope without being [given] false hope where everybody[’s] saying, we aim for recovery. They are going to be aiming for....."
Respondent1: “For management.”
Respondent 3: “Yes.”
Respondent :“So they can have a normal life as normal as they can.” (Respondents, SUCFG 2).
Similarly, different definitions of recovery exist amongst service users and carers; for example:

Respondent 3: “I personally would like to see that but modernised if you like and person centred and not actually called recovery called something you know that is more suited to that person’s needs.”
LF: “So is that around the management of patients rather than...?”
Respondent 3: “Yeah because, because recovery does mean you know you look at the other side of the scale when you talk about people with organic conditions and medical conditions you know, you give them a few tablets and they then go on to recover from the flu or whatever. But you know in certain situations people are never going to recover but they are going to be managed and they are going to be able to enter and have a normal active life within society. And that’s what we aim for.” (Respondents, SUCFG2)

**Role development and career progression**

The theme of lack of role development emerged for many respondents across all staff groups including medicine. Perceptions featured negative relative comparisons between the individuals’ own perception to what they perceived for others. For example:

“I think for nurses there’s a clear progression from you need this to become this to do this. For admin that’s not there. I think that’s something as a Trust we need to look into and develop. If you’re a band two like a stepping up into once you’ve progressed because I know from the admin who I work with, they are a band two, has just recently been in contact with me and she wants to progress to a band three. She doesn’t know how to do it, she’s been around for a couple of years, there’s no jobs available within this Trust..how do we nurture our staff and get them developed..?” (Respondent, SFG3)

Some administrative staff perceived that progression within their current role was becoming harder. For example, this interaction between the lead facilitator (LF) and respondents:

Respondent 5: “What I was going to say was I think what was, what was expected of a grade four job is now expected of a grade three job.”
LF: “In terms of skill?”
Respondent 5: “Yeah.”
Respondent 2: “I think that goes back to....”
Respondent 4: “Yeah I agree, I agree with that”
Respondent 5: “What they expect for you to do in your job role and what qualifications they expect you to have, you have to have everything on earth to get a grade three.” (SFG3)

However, the above perceptions were also questioned. For example:

“I think the skills are determined to the grade and what they’re expected. So I’d probably disagree with what you say, sorry, I think the higher the banding, I do think you have to have specific skills as, like Office Manager or as a Medical Secretary I don’t think, even as a band three secretary I think you’ve got to have specific skills you know. I think they’re very clear in the job specs when you’re look at them the difference in requirements.” (SFG3)

It was suggested by several staff respondents that mistakes were made for training nurses on COPE (psychosocial intervention) courses who returned to generic roles never having the opportunity to practice the new skills, similarly reported by other respondents. Another example was that despite the support for nursing staff to become nurse-prescribers many did not perform the function within their current role. This calls into question the issue of how perceptions may guide organisational behaviours as well as highlighting the need for a more strategic direction for learning and development within the organisations:

“We have now sent band three support workers..on Assistant Practitioner band four courses at two year, part time courses to come back..and there’s no strategy there for how they’re going to develop the posts. So we’ve got four people qualified at band four level who can’t get upgraded because they were sent to do this Strategic Health Authority [course. We] really supported these people..They went off for a day a week for two years to come back to still be band threes and no talk of band four posts being developed..So we’ve had oodles of training sometimes but there’s never been the strategy in place, to utilise it, to say how’s it going to be utilised.” (Respondent, SFG4, emphasis added).

Many respondents reported the above as frustrating for those involved and de-motivating, when effort is put into a course and assessments, and then staff return to their previous role with nothing “extra” being expected of them. A similar theme emerged in relation to HEI programmes:

“We just haven’t got that balance right. I’m not just talking about [this trust] I mean I’ve had significant experience of that [in another trust] where people have come back from degree courses and said “Well what, so what, what do I do now?” And I said well you do your job but you’ve got these enhanced skills but I thought I’d be getting a different job, you know when and I
think you know obviously I stopped setting the stall out much earlier.” (Respondent, SFG4, emphasis added).

This above emerging theme calls into question the set(s) of assumptions that are being made by staff concerning their expectation of role mobility after undertaking higher education, as opposed to undertaking such for sole purposes of optimising their role performance. It also raises another question about the existing strategic planning for workforce development that allows access to programmes of development on an open-ended basis without any apparent rationale for service development. However, more transparency over these issues may be taken forward by using learning contracts:

“I think it’s about getting cuter with...learning contracts I suppose isn't it? You know, this is what we’re willing to provide from our point of view, and this is what our expectations of you are, having undertaken the course, and that all feeding into a strategy, isn’t it, of how you’re developing the service utilising these things?” (Respondent, SFG4, emphasis added).

**Skills and competences**

A theme of employees’ skills and competence emerged from stakeholders relating to the need to establish what a future trust employee should ‘look like’ in terms of their skills, or competences. This theme resonated with the views articulated by staff focus group respondents in relation to designing or redesigning skills for particular workplace environments as opposed to fitting professional skills sets into those environments. For example, the services environment:

“..there might be an assumption being made here in the first place that the skills were designed for the place and not the [the other way round]...that’s my view anyway, that they never have been. I think there’s only a couple of pieces of work that I’ve looked at competency needed in either forensic workplaces but certainly in high secure forensic workplaces in the first place. So skills mix there has generally been historical and mostly accidental. (Respondent, SFG5).

In relation to services, views were expressed concerning the current utility of ‘traditional’ uniprofessional preparation when skills are needed for particular occupational environments that transcend those associated with particular professions. The implication of the above is that skills are not designed for particular occupational settings and that the current demand for these in a modernised service goes beyond, or cuts across, or starts from a different point from those skills sets traditionally associated with uniprofessional preparation. This concept of workforce redesign was a theme that went beyond just the workplace setting.

There was agreement amongst many staff focus group respondents about a need for a set of core competences amongst the trust workforce:
“There’s certainly room for having some sort of core competence and understanding at a particular skill level, isn’t there, and then maybe not developing specialist roles. Because I think for me people go through a period where you develop specialist roles and then all of a sudden somebody says that’s too expensive, or, it’s not working. So actually you can’t, like you said, you can’t be specialist. So actually I want you to do everything again and it seems to me to be backwards and forwards and that but there’s certainly some room for something in between where we do have some core agreed competencies.” (Respondent, SFG2).

Skills and competences were seen as factors not only hard wired into job descriptions but surpassing them, as well as multi-skilling the workforce for quicker patient care. For example:

“..You need your workforce to be able to do more than just their primary job description. And it’s how you build that into the training because they’re not coming in with those skills..It’s about making your workforce multi-skilled, I mean our band 3 nursing assistants can no longer just be band 3 nursing assistants we need them, we’d love them to pick up some physical health care, blood pressures and so forth. Non-medical prescribing is a big thing that we would like a lot of our nurses or staff to be able to non-medically prescribe, so that’s adding pharmaceutical knowledge and it’s kind of I suppose breaking down those barriers between like they’re pharmacy, that’s their specialist, that’s a nurse...you’ve got to have somewhere in between because by the time you’ve referred and gone back...it’s taken so long...you need to be able to get it done quickly...” (Respondent, SG1, emphasis added).

In this regard the Knowledge and Skills Framework escalator (DH 2004b) was cited by several respondents. For example:

“And the level of knowledge and skills you’d have to have to do that job and that’s all what the KSF was about, supposedly, it was about payment for the skills and competencies that you possess, not the actual post or...well the post possess, needed you know but actually so I could have had like ten degrees but the reality is you don’t need them for that job. That if the job says that’s all we’re needed for then I could just get paid an amount that’s but so that gives us choice and career choices” (Respondent, SFG2).

Views were articulated about more flexible and adaptable working roles. For example, in relation to the process of undertaking clinical audit:
“But I can’t say that I need more skills because last time when I was doing audit, you know I used to have to go and discuss with the clinicians what questions they were going to ask, you know, how we were going to put it, how we were going to collect it then I used to collect the data, I used to set up my database, I used to input it, I used to analyse it, nowadays they [the clinicians] collect it you know, the questions are virtually coming from me so we have to sort of analyse them. They’ve tracked the data, it gets fed into this machine that analyses it for me and then we chuck out the results. You know very few, only small ones am I analysing the data. I’m getting paid more for what are really considered to be doing less but what we’re having to do is take control of it and, and monitor it more. And I think you’ve just got to be more adaptable ....” (Respondent, SFG3).

Further indicative examples were given as follows:

- Baseline set of generic transferable skills
- Better use of training investment
  - Staff completing prescribing programmes;
  - Development of staff grade physicians and band 2 staff,

Proven competency was also suggested as a criterion for gaining access to future training, with competences being assessed through some form of secondment, into another part of the organisation. For example,

“[..[Head of Service] suggests we should have people that move around the service so that people don’t get static and stale. I haven’t got an issue with that if it’s based on your IPR and developing new skills, or the fact that you’re performance has already been identified as not quite up to scratch and you need to develop skills. Whichever way, but with some formalized plan so that everybody knows..what I’m supposed to be achieving and some outcome measures.” (Respondent, SFG2).

Some staff suggested this should be granted on the basis that at the end of a given time period there would be some negotiation as whether the staff member could go forward to undertake training depending upon whether they were thought appropriate. However, some therapists indicated that competence assessment was problematic:

“It’s very difficult to see the competence in an interview and, and I think we kind of ask them to do a little sort of plan of how they would treat someone with depression, how they would treat someone with anxiety. And one of the candidates had these quite glossy folders that she came and gave us all one and they looked really nice, how you treat someone with depression. But she just read it and anybody off the street could have picked that up and just did what she did.” (Respondent, SFG2).
Some respondents also pointed to problems with the development of competences, as there seemed to be no end points for these workforce developments. A need was identified to map out what the competences are, and what competences are required, for whichever service model is developed:

“There’s lots of different professions within [the trust], a lot of who see their roles as relatively defined, slightly blurred on the edges but still relatively defined. Is not one of the things that we need to be doing is working out whatever you are..what [skills are needed] to deliver the service to the service users, what are the competencies that we need...the Skills for Health website is very good at saying what competencies you need to draw blood and it doesn’t say you have to be a nurse, it doesn’t say you have to be anything specific. It just itemises a load of skills” (Respondent, SFG1).

This skills/competency theme was extended to discussing how the private sector identifies staff competence and what the potential implications are for staff within the organization if/when becoming more business minded. For example:

“They’re you know lots of services are evolved that way in the NHS that haven’t necessarily come from any sort of qualification base. If we were delivering something that costs money in the sense of a product then they would have to be. And if you went for a job interview they would want very clear evidence that you’ve been successfully managing another service somewhere else before they would appoint you. It wouldn’t be a case of well, you’ve got the appropriate qualifications, they would want to know you can do what you say you can do. Can you do what it says on the box?” (Respondent, SFG2, emphasis added).

For some respondents this new approach was potentially controversial in terms of whether full support would eventually be forthcoming. For example:

“In terms of services evolving, they are evolving clearly. We don’t know what the evolution is going to look like at the end. There won’t be an end process either so what that does indicate is that the staff groups need to evolve whoever they are. And in terms of that evolution [mapping out competencies] is something new to a lot of services; because it won’t necessarily be defined along traditional, professional lines, or boundaries, and we need to be clear about that. Maybe accept it. Maybe not, in terms of what people think.” (Respondent, SFG1).

One commonly articulated theme was of a lack of potential recruits for posts, ward managers in particular. This was attributed to both gaps in the skills of staff and respondents perceptions about the deficits of current education curricula with respect to practical skills base of newly qualified staff:
A key gap for qualified staff I think is leadership, I think there’s a real big gap in their leadership ability because again and I sound like an old person but you know part and parcel of your training [in earlier times] was to take charge of wards.. You were expected to do it, you know very early on into your training to get that experience that supported experience etc until you know you were good to go. Now there [is] very little evidence of any leadership ability and you know when, when ward manager positions become available we can’t get anyone to do them. We can’t get anybody to be even a deputy can we?.. The new style nurse training does certainly seem to have had a big impact on the practical skill base of staff coming through.” (Respondent, SFG4, emphasis added).

‘Newly qualifieds’

A theme of newly qualified nursing staff emerged from both stakeholders and staff focus groups in relation to the perceptions of the type of nursing students undertaking HEI programmes for professional registration and their current level of skill and competence. This theme related to student nurses’: i) orientation to care; and ii) their focus around what it means to care for someone. For example:

“In that having worked in the health service for thirty years, [I’ve] seen a big change in trained nurses. And within recent years, they don’t hit the ground running. They know how to do all the written stuff and all the office work. They can’t relate to patients because they haven’t had that practice.” (Respondent, SFG1, emphasis added).

Similar comments were not recorded in relation to medical students, psychology students, social work students or students of the allied health professions such as occupational therapy and physiotherapy; possibly because the latter professions moved from an apprenticeship model of pre-qualifying education well ahead of nursing or never did experience such a model as in the case of medicine. Together with the above shifts in workforce skills and competences, this perceived additional shift in the demographic of nursing students is viewed as having a potential impact on existing staff’s expectations of the needs of this newly qualified workforce (irrespective of the accuracy of this perception):

“So we’d like newly qualified staff to hit the ground running, you know what I mean? I’d have a lot more [of] that sort of thing, you know, the practice side of training, as well, to be really enhanced, because that’s where they learn that bit.” (Respondent, SFG1 emphasis added).
Service input into selection for pre-qualifying programmes occurs locally and this is seen as desirable because nursing students are now judged to have less competence at point of registration. Some respondents agreed these ‘newly qualifieds’ are not sufficiently prepared to cope with the demands of inpatient units.

However, this viewpoint was balanced in that it was often directly linked by respondents to the how Trusts operate supervision, practice development, mentorship and practice support. In respect of clinical supervision several staff group respondents from services agreed that a perverse equation existed between patient contact hours and the opportunities to receive clinical supervision. For example, the knowledge that emerged from within the following interaction between two respondents and the lead facilitator (LF):

Respondent1: “Generally speaking that the more hours you have with patients, the less chance you have of supervision.”
LF: “That’s an interesting equation.”
Respondent1: “Well it’s perverse. The people who have the most contact with patients should have the most supervision. That’s been a major problem but until, unless funders pay for it, it’s not going to happen. This isn’t…because it’s not criticism of nursing it’s, it’s or any other profession, it’s…”
LF: “So it’s simply a numbers issue then? If, if to release two members of staff for an hour’s clinical supervision you needed two replacements, that, there’s no way financially in terms of…”
Respondent 5: “Well occasionally some…i mean…they can drop numbers occasionally but then you’ve got to think what the consequence or adverse effects on the population, you know engaging with patients throughout the shift is, if there’s less people to do it, if someone goes away. But then the demands on them now there’s also if we go back to like from my point of view, there’s a big issue round capacity. There’s more student nurses than there is placements for them and so quite often there’s more student nurses on that particular placement than there should be which puts more demands on the mentor.” (Respondents, SFG5).

All of the latter impact on the investment made in the ‘newly qualifieds’ and efforts need to be made to enhance their confidence to ensure the safety and the security of themselves, staff and patients. A set of causative factors were advanced for this phenomena by respondents:

- Students own application in terms of what they understand by the nature of mental health work
- Reality of the new work environment: pre-qualifying education is insufficient to prepare students so a significant time is required for preceptorship
- Training doesn’t prepare for, so significant amount of time required to adjust
Students who synergistically engage with the work environment felt confident and move forward, but this synergy was seen as
- Inconsistent
- Not emerging automatically
- Requiring effort to work through

Respondents indicated that more work is required with educational partners on the essential skills expected of newly qualified nursing staff, so when they come into the work environment existing staff do not feel a lack of confidence in supporting their practice as registered nurses.

**Corporate workforce planning**

A theme of having transparency around a corporate workforce plan, together with associated training needs analyses, emerged in relation to respondents saying their organisations needed to tighten up their strategic overview of staff skills and competences. Effective workforce planning ensures NHS provider organisations ensure a workforce of the right size, with the right skills, organised in the right way within an affordable budget so as to enable service delivery for optimum care (Skills for Health 2009). Many NHS providers are adopting the Six Steps Methodology for their corporate workforce plans promoted by Skills for Health (Skills for Health 2009).

In one organisation, respondents could easily volunteer a process for formulating corporate-wide workforce objectives from personal development plans (PDPs) and performance objectives:

“It’s about business planning [defining] what’s the overall Trust objectives...all our PDPs and performance objectives have to fit into those. There’s two ways up, isn’t it? One is how consulted did you feel about those objectives. Some of them will be national ones, won’t they, and others will be locally agreed. And others should have come really from the staff saying actually this is what’s growing. So therefore your training has got to lead into this, hasn’t it? Into what’s the overall objective of the Trust. And if that’s broken down, you know, you’ve got an overall objective that needs to be broken down into steps, doesn’t it? And how do we achieve it? Therefore people need these skills here to achieve this and it all needs tying up a little bit, more doesn’t it?” (Respondent, SFG8).

In the other organisation Personal Development Planning Review process (PDPR or ‘PDRs’) (similar to PDPs) was also seen as a resource for identifying learning needs and legitimising the informal as opposed to formal learning that is currently being undertaken but which may not be transparent:

Respondent 3: “Yeah I mean we’ve got PDRs and everyone has got to have one, by [date], just let you know.”
Respondent 2: “I know, I know, yeah.”
Respondent 3: "And there is a very good section in that where you can identify your learning needs and how you are going to achieve them. And it isn’t just about going on courses. So that’s a way of legitimising some of the informal things we do. But if that was it I think the Trust would be made up wouldn’t they, not asking them to pay for a course." (Respondents, SFG 6)

Some respondents perceived corporate deficits or were unaware of their own corporate workforce planning strategies. For example:

“There isn’t a workforce plan for the Trust that would include everything. We all do our own thing. We’ve all got separate business plans. I’ll have a workforce plan and there’ll be another one somewhere else... there isn’t a corporate workforce plan which [we all] feed into so that you’re aware [of the] whole Trust. The Trust must have aims and objectives doesn’t it in terms of service delivery that says we must do this and then somehow we feed into that. But we don’t do that. It’s very sketchy. Even..things like forward planning for people retiring.. We don’t do anything with that information and we don’t think to ourselves well ok in five years time, because it’s very short term living, because we’re very target performance." (Respondent, SFG4, emphasis added).

The theme of corporate workforce planning was related to concerns around gaining study leave where a need was identified for open and transparent frameworks for decision making over study release and provision; as many respondents reported difficulties with not just obtaining study leave but with lack of a strategic awareness of the need for learning and development within the service which may directly impact on an organisation’s future income or expenditure. For example:

“I applied to go on the nurse prescribing [course], I’d been interviewed and on the day I was told I couldn’t go by [the] more senior manager [as] she didn’t see why I needed to go out prescribing Lithium. She actually didn’t understand what the course was.. [as she said] we just haven’t got the staff for you to go..And now as the Memory Clinics are evolving, if I’d had that skill I actually would have saved the Trust an awful lot of money because they wouldn’t have needed junior doctors to do some of the things that I would have been appropriately qualified, skilled and trained to do.” (Respondent, SFG2).

Administrative staff reported study leave being denied on the basis that they were instrumental for the service so could not be released. However, there were reports of staff undertaking prescriber training and not practising prescribing. Training needs were seen as required building blocks for policy development, as appropriate for the level/staff group. This was seen as greatly helping organisations, as training needs analyses would then be
completed based on actual strategically determined organisational need, desired quality and negotiated in close partnership with academic institutions:

“There is no skills analysis across the board, across the Trust. It’s very individual, left to your own devices and the result, and we just need to you know turn it on it’s head and say what quality do we want to achieve and how are we going to achieve it.” (Respondent, SFG4, emphasis added)

“I mean going back with the solution maybe our learning development, we need to work in a close partnership with the academic institutions to ensure that. At the moment it’s down to primarily down to individual initiative to drive that but we need to come at it from a strategic [position]” (Respondent, SFG8, emphasis added)

The above perceptions from respondents within each organisation suggest that the strategic implementation or deployment of any existing workforce plan may not be transparent. Within one organisation (SFG4) there is a public acknowledgement in the corporate assurance framework of the need to improve implementation of the Trust’s workforce strategy impacting on its ability to effectively plan future services (Mersey Care NHS Trust 2008). This may contribute to the above perception because impact is not felt at the operational level of the above respondent in SFG4. Within the other organisation (SFG8) there is a workforce strategy that each PDR inputs to. Within any workforce plan there would need to be clarity over priorities and how decision are made over what developments to support in terms of mandatory and non-mandatory learning; also allowing for local variation(s). For example:

“What we really need is a system that would allow services to prioritise the non-mandatory training because actually it’s all important, so how do you go about making the decision about what you will support and what you won’t support and at the minute it’s just who’s got the loudest voice or either the best salesman or which report has just come out erm that’s you like the [ ] thing, that’ll be...so I know services will really, certainly my service are really asking for a matrix or a method of allowing decision making to occur for the non-mandatory. Once you’ve decided what your mandatory stuff is, it’s a given isn’t it but for the non-mandatory stuff where it’s desirable, it’s team driven, it’s individually driven, it’s very desirable, it’s essential but not corporate.” (Respondent, SFG1, emphasis added).

**Corporate role in learning and development**

The theme of a corporate role in learning and development emerged as respondents in one organisation noted that there was no single corporate infrastructure to promote or deliver learning and development. In addition,
there was a perceived lack of representation from HEI partners feeding into strategic decision-making around learning and development, training, skills and competences. For example:

“We don’t have those intrinsically within our own directorates so we don’t really know kind of you know what’s out there if you like it’s only from you know going to different network meetings.” (Respondent, SFG5).

This gave rise to feelings that short term-ism existed around future planned organisational change, with the problems surfacing over embedding such change within the organisation:

“So I think we might, could lose focus if we’re not careful about anything to do with training other than ticking a box for mandatory because at the moment that’s all we have to tick a box in. If we can get people through mandatory training then we’re doing well and bearing in mind it could be a week at least out of anybody’s life, training life in the whole of the, the year. So if we tick that box I don’t think anyone else is going to look at it too much and I think that the issue for me is around who’s going to take that strategic view and who’s going to be concerned you know about other quality initiatives because at the moment although we’re talking about quality we’re not measured on quality, even in terms of NICE guidance, it’s just about have you got an action plan, yes. It’s not about well is there a deficit to meet that need, how are you meeting all those needs? It’s not asking those questions, so if we’re not being asked those questions, I’m not sure that we’ll be seeking the answers if that makes sense.” (Respondent, SFG5, emphasis added).

In addition, the above theme pointed to questions over where ultimate responsibility for corporate learning and development lay at Board level, where the systematic expectations and impact of learning and development can expect to be planned and addressed on behalf of the whole organisation. For example:

“I think the other thing that we’ve not been very good at in the past is we’ve probably over the years invested a lot of money in sending people on external courses and degree courses. But what we’ve not been very good at is our expectations of them bringing back that learning and bringing it into the workplace and actually showing what impact that’s had on service delivery. We just tend to send people off on courses and they come back and they’ve passed it and that’s it really.” (Respondent, SFG4, emphasis added).

Respondents’ comments were indicating that at their operational level there needs to be greater evidence of corporate strategic action around assessing
the utility of learning and development programmes and strategic investment across all staff groups as well as a supportive infrastructure.

**Learning and development provision**

The theme of provision of learning and development was related to the following:

- Equipping people to do something versus enhancing their awareness and knowledge
- Skilled negotiation to understand people’s limits and communication
- Abstracting, extracting, receiving information, making sense of it and giving it back to individuals who supplied it in some meaningful form

The various aspects surrounding the theme of learning and development were associated with the different organisations’ capacities for learning and development: either centrally located or within the individual Departments or Directorates facilitated via learning and development networks.

**Service user and carer learning and development**

Individual learning is experienced and required by service users and carers in relation to the challenges of developing in order to recover, get better and remain stable:

“I feel like I’m learning every single day and I feel like I’ve learnt to deal with my ups and downs and that I’ve learnt to be a bit more open in certain areas about what happens and what goes wrong and potential, even the worse things I can do. I’ve learnt to be more honest and recognise them and I just feel like every day is a challenge, every day I’ve got to challenge myself and my attitude sometimes because I can be as you know prejudice about something as maybe the next person but for me it’s all this process, not necessarily geared to [the trust], it’s more about what I do for my own learning needs, how I can build up my own skills and how I can get better every day and try and remain stable.” (Respondent, SUCFG1)

Identified learning and development needs include underpinning the move towards involving service users and carers in formal learning and development. For example, a leadership and empowerment programme at a local HEI requires underpinning with buddying or mentoring provided by service users and carers. These arrangements require longer term planning, the appropriate involvement of a pool of service users and carers, arrangements for payments to be made, and the engagement of service users and carers in curriculum development and delivery. Involvement in learning is seen as an open-ended development:

“..since we’ve had *Change for the Better* and the new ways of working you know, I mean our involvement has been vastly
improved and I feel that we are now valued as individuals and we are encouraged to go [to] any training that either involves staff or whatever. And I think that we’ve come an awful long way and to be honest because we’ve come so far in such a short time I think it’s a question again I can only speak for myself watch this space because it’s an ongoing thing it’s a live document, if you like that, I don’t know what my training will be.” (Respondent, SUCFG2).

Service users and carers own learning and involvement in learning and development may lead to questioning the legitimacy of formal learning in relation to who actually undertakes the latter and whether the their voices are included as indicated by current policy. The following knowledge emerged from the interaction of two service users within a focus group:

Respondent 2: ”I think that leads on to another bit really about who does the training because actually I think we regard you know everything as a liability somehow with having a mental disorder or experience, whatever. It’s emerging that in fact the Trust kind of you know I mean to some degree whether it’s dual diagnosis, a little bit around recovery and a couple of things whatever and certainly elsewhere where there’s more people with experience now delivering training. There is more of this over the last couple of years, than there was a few years ago but I think there’s something around not necessarily in terms of curriculum as such but I suppose that’s just the focus here but actually who delivers the training and I think you know there needs to be a big plea that that training is delivered in collaboration with service users or with carers”
Respondent 5: “Which they’re trying to do to be honest.” (Respondents, SUCFG2, emphasis added)

Trust provision

Overall, the Trust locations were seen as positive sites for learning and development by respondents.

a) Cluster training
Due to the fragmentation and multi-site location of staff clearly identified teams could be trained together in clusters or through peer support

b) Information and communication technology outreach
In relation to clinical audit rather than sitting in an office waiting for staff a more proactive approach would be going out to work on-site with various staff groups or teams. Further themes related to the needs of various groups of non-professional and professional staff to become more productive with the enhanced functionalities now available to the organisations with Outlook Express, new ICT software and the new integrated care record. Update
training on Lorenzo Form8M, OTTER, QUASAR systems was reportedly patchy with some perceiving difficulty in accessing training.

c) In house programmes for teachers
The theme of ad hoc bespoke training emerged in relation to the teachers employed within rehabilitation services who undertake training in the normal route as they are drawn from other areas of professional work within schools. They come without specific mental health or forensic qualifications but do have teaching qualifications and they learn by experience and through undertaking in house programmes related to personality disorder, boundaries and cognitive rehabilitation. Many non-accredited in-house programmes are provided. For example:

“...the group of teachers that we have within the rehabilitation service.. their training is done the normal route. Very often we’re taking teachers from other areas of professional work within schools, perhaps. So we’re looking if we can for experience that they have to bring with them but we don’t ask for specific mental or forensic qualification alongside the teaching qualification and in fact we don’t request or have a need for them to do that, except learning by experience and learning by the sort of usual courses that are run here that relate to things like personality disorder and boundaries and cognitive rehabilitation and so on. So our experience if you like is gained from the internal courses that are run.” (Respondent, SFG5)

d) Learning & development champions, groups and teams
The theme of gathering non-professional and professional staff groups around learning, research and clinical leadership emerged in relation to psychology, medicine and administrative staff. A loose typology of approaches was evident from respondents including learning and development champions, groups and teams of service-based staff involved in learning and development activities. For example, the learning and development champion was described in one organisation in relation to the previous agenda of implementing psychosocial interventions (PSI) within services:

“So now we’ve got a substance misuse worker that’s rolling out a program, the idea is that staff will be supported and develop the skills to incorporate that more fully in their care plans. This one person who’s delivering it isn’t going to be able to manage and complete every care plan. So again it’s very much on that PSI model: you get a champion, you get people on board, you get people to have an understanding and awareness and then they start going out and producing the care plans. They can ring [the champion] up and they can say I’m having a bit of a problem with this...(Respondent, SFG9, emphasis added).

One supported view was that, the provision of CPD activity to address learning needs, clinical interests or clinical developments are not always the responsibility of the employer. Practitioners also realised that they have a
professional responsibility for their own CPD both individually, within their teams and their professional groups. One respondent discussed this as follows:

"..if you want something to happen you have got to do it yourself, you’ve got to make it happen as a staff group. You’ve got to be allowed to identify your own skills needs, what’s important to us as a staff group. Now what’s important to us a staff group is dealing with complex cases, personality disorder cases..lots of people were saying schema therapy that sounds interesting. I can’t afford the training, it means going to New York you know but I’ve read bits of the book, it seems very useful and applicable to the people we’re working with. So I e-mailed invitations to my colleagues, CBT and psychology saying do you want to come along to a, what we’re calling it, an interest group and it’s held here. And that’s, we’ve met two or three times and it’s very stimulating and interesting.” (Respondent, SFG6).

The above acknowledgment indicates how current jobs, and their associated management structures, rely on individual post-holders to optimise capacity and enable staff release for sharing mutually beneficial knowledge. There was also the suggestion that the above interest groups would need to be seen as legitimate by the Trust managers and administrators in order to be allowed access to training rooms and to schedule working time for such meetings. Respondents in one Trust reported some resistance from managers in terms of their undertaking or scheduling such activity as this was considered not to be legitimate as core business. These themes were systemic within that organisation and as such require a strategic overarching approach:

"..We’ve talked a lot about the organisational issues but from an learning and development perspective we actually don’t have the coherent structure to a learning and development strategy do we, we’re fragmented.” (Respondent, SFG1, emphasis added).

The research skills of various professional staff were also seen as under utilised, both within clinical practice roles, and in terms of measuring the impact of learning. A similar finding emerged in relation to newly appointed medical staff for which local programmes of teaching exist through the Deaneries together with peer-organized programmes. Doctors reported having to meet professional requirement of fifty hours in total for internal/external CPD:

"..and then on top of that you would have to meet your professional requirements. Which is fifty hours in total split up internally and externally. So the in house program is your internal hours and then you’re expected to do about twenty five hours external but most of the doctors would get far in excess of that ” (Respondent, SFG5).
Physicians quantified their learning needs in terms of the number of hours for programmes of learning (as above) as well as in their perceptions over the legitimate financial resources required in relation to professional guidance from a Royal College. The latter perception emerged from respondents’ interaction with the lead facilitator (LF) but was not qualified by evidence:

Respondent 4: “Well you could say that there’s sixty, seventy consultants in the Trust. There’s £20,000 in the budget and there should probably £70,000 in the budget.”
Respondent 1: “£1000 per consultant.”
Respondent 4: “It should be £1000 per consultant. So it’s £50,000 under budget.”
LF: “How do you arrive at £1000 per consultant?”
Respondent 4: “Well it’s standard practice across the NHS that it’s £800 to £1000 per consultant. And if you’re an SPR it’s about £750.”
LF: “Is that a Royal College [statistic] and... benchmark?”
Respondent 4: “That’s a Royal College benchmark.”
(Respondents, SFG 10)

e) Personal Development Plans (PDP or similar acronym)
All staffs are required to have personal development plans, or something similar, used as the basis and arising from their performance review. The tool has a section allowing identification of learning needs and a strategy for achievement going beyond purely undertaking courses, but a means of legitimising informal learning; all of which should feed into the organisational plans.

f) Development roles (including preceptorship)
The theme of development roles emerged in relation to discussion of newly qualified staff rotating across different practice areas at six monthly intervals. However, respondents spoke about these concepts in terms akin to the concept of preceptorship. For example:

“The bit that’s missing is the somebody being there on the ward when these staff come back and they’ve been trained and their knowledge is fresh to say well how are you going to put what you’ve learnt into action, what are we going to change?”
(Respondent, SFG4).

g) Work-based learning
The theme of work-based learning emerged in relation to discussion of learning within the workplace and discussion of higher education modules of learning, which may impact on services by requiring clinician time to develop learning outcomes. As the latter modules have generic headings, the content will be specific to the workplace so potentially meeting several needs by building learning around the working environment to enable learners to reach the desired assessment standard.
Furthermore, there were specific inter-professional opportunities identified to meet the specific needs of particular working environments, some of which pointed to the inherent limitations of all uniprofessional health and social care education. For example, the knowledge that emerged from within this following interaction between three staff focus group respondents and the lead facilitator (LF) reflected an aspect of inter-professional learning:

Respondent 1: “If someone’s self harming in front of you, in that sense the training might help you a little bit and probably will because you’ll act in a, you’ll respond in a, professional manner and you’ll know to some extent what to do. But it still provokes things in you that you’ve got to deal with..”
Respondent 5:” No it’s just the same with attitudinal problems isn’t it?”
Respondent 1: “It’s difficult isn’t it, yeah
Respondent 5: “if you, you know someone’s..you know talking to you in a derogatory manner, or shouting at you, you know, you need to know how to deal with that. It’s no use standing up and having a shouting match back type of thing. So, and if you get involved in this you need to be able to engage at, you know, the reasonable level which is going to be helpful and not, you know, inflame the situation.”
Respondent 1:“But that’s counter to what for example lots of nurse training experience is. If you go in, and it’s true for social work and many of the other professions, if you go in because you want to go into a caring profession, to help and stuff, and that’s very rapidly undermined in places like this.”
LF: “So it’s a contradictory intervention you have to make?”
Respondent 1:” Well, when someone is telling you to ‘F*** off’ it’s quite difficult to think why you came in the job wanting to help someone, to put it very bluntly.” (SFG5).
Respondent 2:“And a lot worse.”
Respondent 1:” Yeah and a lot worse, yeah. And not only, and you know, we’ve got, for example, high levels of litigation against staff by patients..We’ve got undermining of staff roles and things, you know, so they’re all, there’s lots of negative characteristics of this specific patient population that are, that perhaps your professional training is never going to equip you to do anyway you know but can only partially….but I think it should perhaps at least someone should have a stab at it and say this might happen and some of the things are a bit counterintuitive. “(SFG5, emphasis added).

There were other aspects of work in particular settings, which were seen as requiring more than that which could be or have been provided by higher education programmes. For example, the latter knowledge was reflected in the awareness of particular learning and development that emerged from within the following interaction between three respondents in one staff focus group:
Respondent 2: “I don’t think we’ve mentioned the security staff at the beginning did we?”
Respondent 1: “That’s, sorry, that’s another group and they’ve got very specific needs. Where, where would you learn to do a room search...you know on any course. You know we’ve been again, we’re looking at setting up that stuff ourselves and then become the business units, sell it but...because there’s other places that need it but...”
Respondent 5: “There’s one thing searching this room systematically and there’s another thing searching this room when there’s a patient breathing down your neck, shouting abuse and what...you know, and threats.”
Respondent 1: “And finding anything.”
Respondent 5: “Yeah, yeah, and stopping when you’ve found it.” (SFG4)

In addition, the additional experiential learning and development required to successfully function within particular settings was seen to need theoretical support currently not included within professional curricula. For example, this knowledge emerged from the interaction of three respondents and the lead facilitator (LF) within one staff focus group:

LF: “...what you seem to be saying if I’ve heard it right [is] that you know these educational needs, no education provider could meet them all because of the specific nature of them [Respondent 1: “Yeah, that’s true”] but maybe more could be done in relation to...
Respondent 1: “Well you’ve got to...”
Respondent : “You could do some of the theory stuff....”
Respondent 1: “Yes, I mean to be honest it’s...”
Respondent 5: “…the experience that goes with it.”
Respondent 1: “Yes and you can’t experience perhaps working in here. You can only do that by placements in a sense but you know and I’ll own this one...it is absurd that mental health professionals of any nature but predominantly nurses and, but other ones as well, are coming off mental health courses having not covered the major mental disorders. And there’s a ratio of something like 10:1 personality disordered individuals in Britain compared to everyone who is psychotic. So that is absurd.”
LF: “You’re saying...”
Respondent 1: “You’re ten times more likely in your professional career to meet someone with a personality disorder and you don’t get a days training on it. And that’s madness.”(Respondents, SFG9).

Furthermore, the notion of learning within a placement or secondment was seen as having limitations in respect of some services due to the nature of relational security
“The difficulty with it is that much of the work is done within medium and well any secure services around relational security that’s where you build up the relationship with individuals, a therapeutic relationship which builds trust, respect, dependence, an appropriate dependence sharing and openness, honesty. And obviously somebody else bringing into that dynamic will impact upon it. And I suppose what you were always aiming towards with a mentor with a student is vicarious learning. But that is always limited because the real quality aspect of the learning will be when people are on their own two feet and doing ...” (Respondent, SFG9, emphasis added).

**Partnership provision**

a) Local authorities
The theme of local authorities emerged from partnership learning and development activity around safeguarding children with a local authority. One organisation is responsible for safeguarding children in services so they forged a partnership with local safeguarding children services and undertake joint initiatives for induction training and ongoing supervision in services. This partnership development is considered important given the outcomes of previous public enquiries and because of the specific profile of the patient population.

b) Higher education institutions (HEIs)
The theme of HEIs emerged in relation to two different perspectives. On the one hand, working with HEIs was seen as a partnership to develop a workforce that welcomes and supports learning and development. However, due to the stretching of current resources staff may become stressed and a tendency may surface to view students and learning situations as burdensome. This capacity issue needs to be managed to enable staff to be able to engage because HEIs are learning and development organisations undertaking their agreed role in a partnership by developing knowledge so that organisations and staff can develop appropriate skills.

On the other hand, HEIs were seen as out of touch with what is happening in practice as academics have been in HEIs for many years, and not necessarily involved in service delivery or management due to a lack of engagement or involvement with service providers and communities also due to catering for large student numbers. Teaching that goes beyond purely diagnostic categories (schizophrenia manic depression etc) to address the wider issues around how people live, was seen to require academics to become part of the mental health service teams; with a variety of means for achieving such an objective either by lecturing within Trusts or by clinical work or leading research projects within the teams. Such posts could involve joint appointments between HEIs and Trusts and these have been established by both organisations.

Respondents reported instances of colleagues not completing various HEI programmes. Multiple causes were identified including poor assessment of
what training is required to lack of strategic identification of required skills within the organisation and between the organisation and Strategic Health Authority. For example;

“I think the responsibility from my point of view lies with the Strategic Health Authority being more engaged with the Trusts to think about realistically how do we know? Again it goes back to skills in working out what skills you need within your workforce. I don’t think we’ve got that right within our organisation somehow. So then we can actually say to the Strategic Health Authority when they offer ten places on an Assistant Practitioner course and you’ve got to fill them, well actually will they give us the skills that we need in our workforce today for the next twelve months, five years, whatever. No, so lets have just a few assistant practitioners but COPE, whatever the course that we need more of that you know and some transfer some funding over so that’s flexibility instead of…it seems to me, I don’t understand it totally but Strategic Health Authority come along and say somewhere we’ve got this money, we’re going to pay for so many places to access this amount of knowledge and course but and then Trusts have to rummage around and say, god who do we need to put on these you know, when we’re in the middle of redesigning our services, so we’re not sure what skills we are going to need, we probably needed them five years ago but actually the next five years, we don’t want that, or we want a few people with that but we want..we’re not sure” (Respondent, SFG2)

c) Community-based organisations
Extending the organisational partnerships between colleges of higher and further education to housing, transport and education and adopting a public health approach was suggested, in order to work around poverty and social inclusion. As education providers are only one potential partner the issues of who to partner with are broad. One example given was that of Everton in the Community; an example of community engagement for training service users to become football coaches. As a programme, its area of expertise does not lie within a HEI, it lies in the social system of a football club, part of Everton Disability, who have a team who may well themselves have disabilities and whose purpose is to encourage participation. Each Community Mental Health Team now has a league comprised of both staff and service users that play together. On the back of this development, users are receiving coaching from staff at Everton who provide training in coaching skills.

d) Consortia
The theme of consortia emerged in relation to the provision of learning and development around learning difficulties services. Access to a consortium was seen to convey additional training opportunities like joint-training partnerships, as well as better resources because collectively partners can provide more resources. Each stakeholder has representation and can influence the nature of the provision in order to request bespoke programmes. Although this
provision falls outside the usual domain of HEI's, relationships exist with The University of Chester for access to specific higher education modules.

e) Practice-based programmes
Accrediting practice is a theme that emerged as respondents considered they are currently able to offer a model of practice-based education that may attract academic credit from local HEIs. Supported views were expressed that the Trust as a corporate organisation had the skills, capabilities and clinical placements available to not only deliver in-house courses and mandatory content for programmes at local HEIs; but also to propose a business case for a Foundation Trust (or its equivalent) considering how to gain some form of HEI status so as to offer academic awards and maximise income generation across a range of existing programmes that already address the needs of an external niche market. For example, the placement circuit for such a plan was described as follows:

“If I was opening a school of nursing that encompasses [the two organisations] that has got community placements: they’ve got drug and alcohol; they’ve got geriatrics; psycho-geriatrics; they’ve got child adolescent; they’ve got the ability to be able to expose our young breed to all these things...[students could be sent to] the [secure services] for the next six months and [there] you’re going to learn and I expect you to be able to describe and finish this essay off at the end of the time. And it’ll be clinical business units (CBUs) and psychosocial interventions (PSI) and you’ll spend a period of time every week, three days on the ward and two days in college. or whatever it is, to make sure that you’re on track that you’re getting that supervision, whatever you want to call it. (Respondent, SFG9).

In addition definite rationales were articulated to underpin these perspectives about the relationship of theory/practice, and the legitimate sources of influence for any curriculum:

“I think it’s an iterative sort of situation which flits back and forward. You know, where does theory come from? Does it come from practice, or does practice come from theory? You know, my view is that theory comes from practice because there wasn’t a book written on psychiatry however many hundred years ago [until] someone started practicing psychiatry. Someone started, you know, so I think we’re the kind of pioneers - not the right word - but we’re certainly the people who should be influencing what the curriculum should look like.” (Respondent, SFG9).

Challenges and Opportunities for Future Mental Health Services

A variety of specific challenges and opportunities were identified by respondents to be considered as part of the future development of mental health services. (Figure 7).
### Collaborative working
- Multi-disciplinary working variable often due to local relationships
- Learning to work collaboratively (collaborate/compete) with the private sector (become more astute with business skills)

### Vision
- Realise how Mental Health Care can be different and doing things differently
- Move away from inpatient services to more locally based closer to home services (crisis type) to prevent unnecessary admissions
- More providers
- Change from custodial to therapeutic care
- Shift to primary care
- Shift from institutional care to caring for ill people in the community
- Challenge of increasing client numbers with a potentially reduced public finance for services

### Unique (care) needs
- Increased morbidity in prison populations
- Patient outcome measures with focus on prevention and recovery not only clinical outcome measures
- Focus on the individual and complexity
- Difference to other forms of adult care e.g. Myocardial Infarction, Coronary Heart Disease; Cardiac Arrests; no infrastructure in mental health services in the same way; junior people taking on serious responsibilities with no track record.

### Learning and development
- Change to produce something novel using existing resources
- Learning and development required to:
  - Capture peoples’ spirit
  - Enable people
  - Take risks
  - Produce innovative/exciting outputs
- Tranches of training come with new policies/regulation e.g. Independent Mental Capacity Advocate
- E-learning
- Challenge between those who want to deliver and tick the box and those who want to help people grow and learn (sometimes able to reconcile these different aspects)

These echo the themes identified for learning and development needs as well as being influenced by national and local policy drivers and organisational drivers as previously presented in the Key Findings. These opportunities and challenges include collaborative working with a variety of agencies and
providers from, both the public and private sector, vision for change, recognition of the unique but diverse range of care needs of both service users and carers. And, the learning and development required for their organisations, staff, service users and carers and other organisations they work in partnership with for the development of mental health services provision. This involves a change of focus from mental illness and institutional care to a range of services being provided across a variety of locations with a focus on promotion of mental health and well-being, prevention and recovery.
DISCUSSION

Limitations of the Study

It is acknowledged that there are limitations in the approaches to sampling and data collection taken. For example, working within the Trust’s existing consultative mechanisms meant that the range of views incorporated into the focus groups are only those of members of the Learning and Development Forums, self selecting staff groups and representatives of the Service User and Carer Forums and may not be fully representative all employees, service users or carers. However, it is thought by virtue of the fact that the focus group participants are members of the Trusts’ Learning and Development and Service User and Carer forums or staff groups they have particular expressed interest, commitment and expertise in the subject area of mental health services provision. Interviews with key stakeholders, a convenience sample of directors, have provided a broader strategic context from which to inform and compare and contrast the themes and issues identified. Use of direct quotes to illustrate themes has allowed ‘voices’ to be heard as well as staff and service users and carers being able to participate in the consultative process of identifying future workforce development needs.

Modernisation Agenda


One key imperative is for a balance between the current drive towards episodic ‘quick-fix’ interventions, to providing longer term rehabilitation and maintenance interventions based on recovery models, measures and outcomes from the perspectives of clinicians and service users and carers (NHS North West 2008). Whilst the former may require cognitive behavioral and analytical skills, the latter require more supportive engagements where clinicians deploy rehabilitative, care planning and case management skills within psychosocially focused partnerships with service users and carers, as evident in the practice of community support workers. Evidence of extensive learning provision was evident for the former approaches with none or limited evidence for the latter. An imperative exists for identifying the learning provision for rehabilitation, care planning and case management.

Another imperative is that the complexity of co-existing clinical needs around drug or alcohol use, personality problems and self harm require more integration of care provision whilst also revealing skill deficits in existing workforce (Skills for Health 2009, Skills for Care 2009). For example, in assessing and treating physical care needs. Given that knowledge of a
person’s psychiatric diagnosis may skew the whole focus in service delivery, there is a further imperative to challenge existing practices and to reappraise how physical assessments of people with psychiatric diagnoses are undertaken in primary and secondary care exploring existing resources like the Time to Change campaign (c.f. Time to Change 2008 cited in NHS North West 2008 p.27). As embedding recovery is reportedly problematic, and complicated by different understandings, efforts should be made to use recommended tools for assessing service performance (NHS North West 2008).

Perceptions over an inability to evidence service quality or volume and capacity leading to potential loss of commissioned contracts are balanced by an awareness that some staff are (still) embedded in notions of a ‘job for life’ and in preserving a status quo. There is an imperative to actively engage in identifying new ways of learning (and thinking about learning) in order to underpin improved service performance; with service users and carers perceiving an active role within this activity (NHS North West 2008). There is evidence of service users and carers being involved with learning and development opportunities with staff in both Trusts and with local HEIs but their specific needs may also to be a continuing focus with longer term planning. A clear imperative also exists for Trusts to develop strategies for managing the uncertainty generated by the effects of organisational change and for trust learning and development functions to capitalise on renewed staff learning interests.

Professionals see service users undertaking self-care and being involved with their needs assessments and service planning. Service users and carers are more modest and mindful of their limitations for navigating what they see as obstructive regulations and discriminatory practices around medication and benefits. Some service users can envisage their role shifting towards marketing services to ensure funding just as some professional staff foresee, service users and carers having greater contribution in future service organisation and development. The ‘best’ learning and development opportunities now must include service users and carers as co-teachers and/or peer recipients of professional services. Initiatives exist in each Trust for involving professionals and service users and carers in learning and development activity and in staff recruitment (NHS North West 2008), which are recognised strengths. However, an imperative exists to analyse the disparate perceptions surrounding user involvement to inform consensus opinion across different stakeholders (providers, staff, service users and carers) as to what this constitutes and how it should be undertaken. In so doing, a local evidence base can be developed for optimising service user and carer involvement.

**Quality, Outcomes and Business Principles**

Embedding the principles of quality, efficiency and effectiveness to underpin service delivery (Darzi 2008) is an imperative for Trusts, universities and individual staff. Providers and commissioners are required to use outcomes that are meaningful to service users and carers (NHS North West 2008).
Evidence is required for continual review of the quality of service experience for users and carers linked to payment by results, market competition, and testing the need for modes of delivery (Darzi 2008). There is a renewed imperative for joint service user, carer and staff learning and development on leadership, enterprise, innovative lateral thinking (creativity), quality, marketing and service tendering (NHS North West 2008). With more service users and carers becoming involved with formal education programmes, further work is required to explore their experiences in such provision. This renewed imperative is tempered by an acknowledgement that embedding market principles within service delivery is inevitable but may have unintended consequences linked to the nature of commissioning, performance management, market competition and service contracting.

**Learning, Development and Workforce Planning**

Different infrastructures for learning and development exist within 5 Boroughs Partnership NHS Trust and Mersey Care NHS Trust. Each Trust already shares experiences of learning and development and workforce planning with the other at the strategic and planning level but this is not evident from the sample at an operational level. It was noticeable that within focus groups references were not made to the other Trust by name. Figure 5 lists the learning and development needs identified from service users and carers and staff that can be used in benchmarking future work based learning activity as well as inform future learning and development strategies, planning and commissioning.

There is an imperative to develop better local knowledge, understanding and transparency about how formal education programmes are commissioned, and the precise stake each NHS Trust (in particular its staff groups) has within these processes. There is an imperative to clarify exactly how existing contracts with local education providers can help Trusts meet their existing and future organisational development needs.

Service users and carers are involved in formal and informal programmes of learning and development requiring planning, payment and engagement in curriculum development and delivery (NHS North West 2008). Workplace learning provision occurs through a variety of different formal and informal modes as cited above. An imperative exists to map current Trust-based provision and to assess the potential for income generation, and joint learning activities on behalf of both Trusts, so as to maximise their organisational returns and develop more strategic working with education providers. A perverse equation which requires further exploration is a reported perception or link between increased patient contact hours and reduced opportunities for clinical and student supervision within services.

Some staff groups undertake extensive learning without developing their existing roles, either because of lack of opportunity, or because previously those roles never required enhanced competences. It is therefore important to understand and justify staff assumptions and expectations guiding their choices of learning and development and how these map against existing
strategic workforce plans to ensure access to programmes have clear rationales for service development or enhanced role performance. More transparency over these issues may occur through corporate use of individual learning contracts monitored Trust wide as part of individual performance review and professional development.

Greater transparency around the processes of gaining study leave with an appreciation by managers of staffs need for informal learning and development and their fit with corporate requirements could be strengthen and develop existing approaches. This demonstrates the need to identify and use local evidence to inform organisational development and underpin a strategic approach to learning and development (Skills for Care 2009, Skills for Health 2009). This could be assured by using the Performance Review mechanisms for all staff within each Trust to develop and annually evaluate their Professional/Personal Development Plans that can be used to inform both workforce development and learning and development strategies and planning.

Within Mersey Care NHS Trust the corporate assurance framework identifies the risks associated with the implementation of the Trust’s workforce strategy (Mersey Care NHS Trust 2008). A perceived lack of impact of this strategy could have a negative effect on the Trust’s ability to effectively plan future services (Mersey Care NHS Trust 2008). A finding of the focus groups (e.g. SFG4), was a perceived lack of impact or knowledge of such strategies at the operational level sampled. Within the 5 Boroughs Partnership NHS Trust (e.g. SFG8) there maybe a workforce strategy and plan into which individual performance review and personal development plans can inform and be informed by (5 Boroughs Partnership NHS Trust 2007), but again at the operational level sampled it appears this may not be fully appreciated or functional, or functioning at a less than optimal level so as not to be reported by respondents. Within any workforce plan there should be clarity over priorities (Skills for Health 2009, Skills for Care 2009), and decision making over which learning developments the organisation supports, in terms of mandatory and non-mandatory learning; also allowing for local variation(s). While stakeholders appreciated this, such clarity was not apparent at the operational levels of the focus groups.

Skills and Competences

There is a need to establish what future Trust employees require in terms of requisite skills and competences for particular roles and environments as opposed to commissioning traditional skills sets. In services there is concern about the current utility of ‘traditional’ uni-professional preparation. A need was highlighted for a set of core competences for each staff group. A multi-skilled workforce with transferable skills can achieve more responsive services through flexible, adaptable and integrated work roles or inter-disciplinary working (DH 2004). Better use of the broader or enhanced skills and competences of professional groups may deliver more value for money e.g. rehabilitation by those with generic or specific skills, research led by those with enhanced skills.
Proven competence could be explored as one criterion for gaining access to future formal learning with assessment via secondments within Trusts. Competence assessment is seen as inherently problematic e.g. how do you ‘prove’ competency at formal job interview for a cognitive behavioural therapist post, which was an issue identified by focus group respondents. Excitement and concern co-exist over the development of competences in relation to the lack of end points in workforce development; a service could logically evolve according to market needs and likewise job roles evolve unlinked to received wisdom over what professionals ‘do’ or evidence based on individual performance review and informed by personal development plans. An imperative is to map out what competences exist and what are required for whichever service models are required and evolve for future mental health services.

The local demographic and perceptions of the ‘newly qualified’ nursing staff is reportedly changing in terms of skill, competence, orientation of care and changed focus on the meaning of care. This purported shift is said to impact on staff expectations of the needs of the ‘newly qualified’ workforce, which was thought to require more preceptorship on starting employment at point of registration. A set of causative factors are advanced (as above). These shifts were also directly linked to the operational work within Trusts around supervision, practice development, mentorship and practice support. Deficits in recruiting to posts, ward managers in particular, were thought to be due to inexperience partially attributed to perceived deficits in HEI curricula, a lack of suitably qualified candidates or a reluctance to apply. The reasons for this need to be better understood by Trusts particularly as ‘role development and career progression’ was a clear theme from all staff focus groups irrespective of discipline. An imperative exists to explore these perceptions in partnership with local education providers and Trusts. Similar observations were not reported for all health and social care students. The reasons for this omission is unclear given the Trusts sampled provide extensive placement experience for all health and social care students. Observations on the current performance of all health and social care students should be sought due to potential organisational impacts.

CONCLUSION

Consideration of all of the above points discussed could assist the Trusts to take forward their workforce planning agendas and learning and development strategies and plans informed by sound evidence and management to ensure that their organisations, workforces and staff are able to deliver mental health services required for the future. The range of these issues is broad and involves new ways of organising and delivering services, commissioning, inter-agency and partnership working, modernisation, staff development, service user and carer involvement, person and family centred care with outcomes focused on prevention, mental health and well-being, recovery and self-care. Whilst their scope is broad and a challenge they are opportunities to develop mental health services responsive to the needs of local populations that are fit for purpose and of value.
RECOMMENDATIONS

Based on the above findings, it is recommended that Mersey Care NHS Trust and 5 Boroughs Partnership NHS Trust consider undertaking the following either individually as Trusts, collaboratively by joint partnership working or by brokerage with each Trust undertaking aspects on behalf of the other Trust in relation to review or function:

Service Users and Carers Involvement

1. Examine how services may better integrate care for people with ‘dual or multiple diagnoses’, such drug and alcohol use, personality problems and self harm and identify any further requirements for workforce skills and how learning and development can be addressed.

2. For people with psychiatric diagnoses identify and challenge current practices around physical assessment in primary and secondary care using existing resources (e.g. Time to Change Campaign) to locally mobilise improvements.

3. Ensure recommended tools are used for measuring service performance in relation to recovery models, markers and outcomes from clinicians and service user and carers’ perspectives (e.g. Recovery Markers used by the Mental Health Centre of Denver USA, cited in NHS North West 2008).

4. Continue to capture and evaluate the local experiences of service users and carers as they become involved in developing and delivering informal and formal education programmes.

5. Survey stakeholders’ perceptions about user and carer involvement to develop consensus opinion across different stakeholders to optimise opportunities and contributions.

6. Compare existing service user and carer focused outcomes as a basis to develop or incorporate new outcome measures of service and care experience.

Organisational and Staff Developments

7. Develop a human resources strategy for managing uncertainty generated by organisational change.

8. Assess the ongoing impact of workforce strategies and plans within each Trust in relation to learning and development, individual performance reviews and personal development planning as the basis for future developments.

9. Identify a set of core competences for each staff group.
10. Identify how skills and competences in job descriptions change over time and in relation to the post-holders and their roles.

11. Identify the core or generic and broader or enhanced skills and competences of each professional group and identify how these skills are best applied in the workplace.

12. Determine what skills and competences exist and identify what are required for evolving service models.

13. Identify which learning and development resources support the practices of rehabilitation, care planning and care management for recovery.

14. Share experiences and outputs of learning and development and workforce planning at strategic and operational levels to provide evidence and justification as basis for decision-making.

15. Monitor which staff groups have undertaken learning opportunities without subsequent role developments and identify the reasons why.

16. Survey staff assumptions and expectations around their own professional and non-professional learning and development.

17. Identify if learning contracts are being used and assess the potential utility of deploying these or similar tools Trust wide.

18. Identify and disseminate how different staff groups gain study leave describing the various processes

19. Survey the views of managers on informal learning/development.

**Commissioning Learning and Development, Collaboration and Partnership Working**

20. Adopt as an education commissioning standard joint service user and carers and staff in learning and development.

21. Develop better local knowledge, understanding and transparency about how formal education programmes are commissioned and the stake NHS Trusts and their staff groups have within these processes.

22. Undertake a scoping study to identify current work-based learning provision and opportunities and assess the potential for income generation.

23. Undertake joint-learning activities with the aim of maximising organisational gains for more strategic work with local education providers.
24. In partnership with service users and carers describe existing innovations in workplace learning to underpin improved service performance.

25. Identify how provider organisations, universities and individual staff members are working to embed the principles of quality, efficiency and effectiveness to underpin service delivery.

26. Clarify how existing contracts with local education providers can help existing and future organisational development and business needs of service providers.

27. In partnership with education providers measure the level of performance of health and social care students and assess how their performance level impacts on service providers at point of professional registration.

28. Explore the link between patient contact hours and staff opportunities for clinical and student supervision within services.
REFERENCES


5 Boroughs Partnership NHS Trust Board Papers (2009). Board Papers 24/2/09 version 2. Warrington, 5BP.


Department of Health (2003a) Fast-Forwarding Primary Care Mental Health ‘Gateway Worker’, London, DH.


Department of Health (2003c) Fast-Forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers – Best Practice Guidance, London, DH.


