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New ways of working in acute inpatient care: a case for change

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Abstract
This position paper focuses on the current tensions and challenges of aligning inpatient care with innovations in mental health services. It argues that a cultural shift is required within inpatient services. Obstacles to change including traditional perceptions of the role and responsibilities of the psychiatrist are discussed. The paper urges all staff working in acute care to reflect on the service that they provide, and to consider how the adoption of new ways of working might revolutionise the organisational culture. This cultural shift offers inpatient staff the opportunity to fully utilise their expertise. New ways of working may be perceived as a threat to existing roles and responsibilities or as an exciting opportunity for professional development with increased job satisfaction. Above all, the move to new ways of working, which is gathering pace throughout the UK, could offer service users a quality of care that meets their needs and expectations.

Key words
acute inpatient unit; service user expectations; workplace culture; whole system working; NWW for psychiatrists; multidisciplinary team responsibilities

Introduction
This position paper aims to describe the current tensions and challenges of providing inpatient care in line with contemporary mental health services.

The acute inpatient ward is regarded as a key component of mental health care in the UK; indeed around two-thirds of available (NHS mental health) financial resources go to support acute inpatient services, and they remain the principle method for dealing with disabling mental health crisis.

Over the past 30 or so years, there has been a shift from the inpatient ward as a place of treatment, towards a more community based approach leading to a decrease in the numbers of available beds (Thornicroft & Tansella, 2002). Consequently, the threshold for admission has risen dramatically and inpatient services in many places operate as a crisis service leaving little time for therapeutic interventions (Allen & Jones, 2002).

Service users themselves report being bored and, not uncommonly, threatened while in inpatient facilities, and unhappy with the quality of care they receive; clearly there needs to be a shift in the way that those who work on acute inpatient wards go about their work if the needs of service users and their families and carers are to be met (MIND, 2004).

The New Ways of Working in Mental Health component of the National Workforce Programme provides an important focus for redirecting activities in acute inpatient wards and an opportunity to engage with others who are striving to change an often difficult and intractable system (DoH, 2004).

Background
In 2000 the government identified mental health as one of three national priorities, along with cancer care and coronary heart disease. This setting of new priorities happened at a time when the UK government was making explicit its plans to increase the amount of funding for the NHS to match that of its EU counterparts; it would equate to 9% of gross domestic product (GDP) (Kings Fund, 2005).

What this has meant for mental health is interesting: 12.2% of the total budget for the NHS is reserved for mental health (Audit Commission, 2006b). This represents an increase of 25% (£983m) from £3,770m in
2001/2002 to £4,679m in 2005/2006 (Mental Health Strategies, 2006) for adult mental health services. If the budgets for other age groups and capital spend are added, then the total budget for mental health (including learning disabilities) is £7,200m (Audit Commission, 2006a; Mental Health Strategies, 2006).

Although these sums describe the allocation intended for mental health, they do not represent actual spend, nor the amount required to meet need in any particular area. However, it is clear that budgets for mental health services have increased substantially over the past decade.

Of course, such large increases in budget are not without ‘strings’ and mental health services (and commissioners) were required to increase spending in key priority areas, for example assertive outreach teams, crisis resolution and home treatment teams, early intervention in psychosis teams, graduate workers in primary care mental health and community development workers (CDWs). Investment in these priority areas alone increased substantially from £78m to almost £300m over the five years leading up to 2005/06.

This increase in support for more community focused services, as opposed to hospital based services, is entirely consistent with research and policy, and reflects acknowledged good practice in mental health (Thornicroft & Tansella, 2002). However, while there continues to be a significant shift to more community-based services, most financial resources in mental health continue to be used to support inpatient services (Mental Health Strategies, 2006).

Nevertheless, the resources to provide overall services continue to improve year on year. Despite these increases in funding and the development of new community service models, inpatient services play (and will continue to play) a significant role in the care and treatment for people with a mental health problem. The key question is whether these services have changed and adapted to the needs of service users and carers at the same rate as community services.

Despite this increase in funding, and the increasing trend towards commissioning services outside the statutory sector, most NHS mental health service provider organisations continue to provide the bulk of service provision. As such, acute inpatient facilities continue to be seen as primary functions of a mental health service (Mental Health Strategies, 2006). At the same time, experiences of the acute inpatient unit are the single largest source of formal complaints and seemingly, a series of surveys and reviews confirm the unsatisfactory nature of those events (MIND, 2004).

Collaboration between the Department of Health (DoH), the National Institute for Mental Health (England) (NIMHE)/Care Services Improvement Partnership (CSIP) and other bodies, led to the establishment of the acute inpatient programme that resulted in the setting up of local inpatient fora (DoH, 2002). This has resulted in the development of a set of standards for acute mental health inpatient facilities by the Healthcare Commission, which are now in use as an assessment framework, underpinning reviews of acute inpatient services (2007). There are good reasons to believe that this process will stimulate some change and improvement, but the perceived role of the ‘psychiatric ward’, professional and informal practices it supports, and the workplace culture that maintains them all have deep roots in earlier expressions of mental health policy. The asylum model of the past socially isolated service users and segregated the staff in remote locations divorced from the community and its services, encouraging institutionalised practices (Nolan, 1993; Thornicroft & Tansella, 2002).

Continuing expressions of dissatisfaction with the acute inpatient units reflect the difficulties encountered in attempting to change these, which may be why these services have not changed and adapted to the needs of service users at the same rate as community services.

**Expectations of a contemporary acute inpatient facility**

The commonly held view that more traditional services for people with mental health problems include admission to hospital at times of crisis is overly simplistic. The role of the acute inpatient unit is much more complex and demands a high degree of skill and teamwork. The people admitted today are, usually, more severely ill than people who were hospitalised in the past (Rethink, 2007).

It is true that the reduction in the numbers of beds has led to a rise in the threshold for admission (Brooker et al, 2007). Under these circumstances, the skills required when making an accurate diagnosis and assessment of the
The formulation of a plan of care and interventions based on a series of systematic assessments requires input from a team of people (including the service user and their family/carer) who are well trained and effectively led (Clarke, 2004).

The nature of an acute crisis will often involve an assessment of risk, usually to the service user themselves but occasionally to others, and again this requires contributions from a range of people across different specialities and professional groups, therefore admission to hospital should be regarded as just one component of the whole complex system of care (Sainsbury Centre for Mental Health, 2005).

Once assessments have been completed and a plan of action agreed with the service user and all those involved, decisions need to be made about who will carry out the different actions, where the actions will be carried out and how the process will be managed. An important part of this decision making process should focus on the point at which the service user will be discharged from inpatient care, thus allowing treatment and support to be continued in their own home (Royal College of Psychiatrists, 2006b).

This last point is central, and will often involve a careful consideration of risk and the person’s social circumstances, as well as an evaluation of the factors that led to admission. Comparisons of severity may be made with people who are awaiting admission. This process necessitates closer integration of inpatient and community services with early follow up after discharge (Meehan et al, 2006).

Although still a somewhat simplistic description, this process should ensure that people enter hospital only when necessary, are discharged as quickly as possible, and have a service that is based on the best available evidence that meets their needs.

Experiences of a contemporary acute inpatient facility
Surveys of service users’ experiences of acute inpatient care describe a more worrying situation (MIND, 2004): 53% of respondents felt that the ward surroundings had not helped their recovery and 31% that it had made their condition worse. Only 20% of respondents felt that they were treated with dignity and respect by staff, and overall the service users’ unhappiness with their experience in hospital focused on boredom, staff attitudes, understaffing and temporary staffing (bank staff and locums) and the physical environment.

This view was reinforced in the 2005 Chief Nursing Officer’s Review of Mental Health Nursing, where a systematic review of the literature on service users and carers views on mental health nursing in the UK found that the use of agency staff, high staff turnover and high sickness rates all contributed to a lack of continuity of care and little or infrequent contact with key staff, although there is a downward trend in the employment of locum staff (Bee et al, 2005).

Those qualities that service users value the most in mental health nurses, who provide the vast majority of acute in-patient staff, are exactly those qualities that the services users report as missing in their interactions with staff in acute inpatient settings. More specifically service users want staff who work in a collaborative way, are flexible, treat them with respect and value them as people, exactly those qualities described in the 10 Essential Shared Capabilities (NIMHE, 2004; Baguley et al, 2007).

It seems clear that, if acute inpatient services are to meet the needs of those people who use their services, then change to at least some parts of the system is vital. Many services continue to carry out case reviews in the form of ward rounds, a pervasive approach that maintains an outmoded workplace culture focused upon ‘treatment’ and risk management rather than recovery. Ward rounds continue despite reports from service users that they find them intimidating, demeaning and often humiliating, and increasing understanding that they are wasteful in the use of time of all concerned, including service users and carers as well as nursing staff (Foster et al, 1991; NIMHE, 2007).

Recently the Royal College of Psychiatrists (2006b) stated that a full multidisciplinary ward round should occur at least once a week to fulfil the accreditation standards for acute mental health wards. This requirement, together with the responsibility that consultants feel for outpatients and service users in the community, influences their relationships with service users and with other professional groups, and makes meaningful change difficult to achieve (Williams & Cormac, 2007).
A contemporary acute mental health services model

One of the major investments in mental health services has been the introduction of crisis intervention and home treatment teams. This has been led in large part by recognition of the high rates of brief admission driven by needs that could have been met differently. The success of this strategy can be seen in the particularly rapidly falling rates of admission in trusts where crisis resolution and home treatment teams have been established (Glover et al., 2006). What it also forces is reappraisal of the role and function of the acute inpatient unit. These can no longer operate in isolation, divorced from psychosocial aspects of care. The bio-psychosocial model underpins care delivery in community settings, and acute inpatient units need to match this focus instead of centring on a medical perspective and risk management (Allen & Jones, 2002; Clarke, 2004).

The recent CRHT survey (Onyett et al., 2006) draws further attention to the need for mental health services to find ways of operating as a complex whole rather than separate silos. This needs to include the development of stronger links between inpatient services and others involved in providing care, such as social workers and the voluntary sector. It must also be recognised that service users’ needs for socially relevant aspects of care do not stop just because they have been admitted, indeed in most cases they intensify. For example, there may be issues around family and social networks that may need to be addressed in order to facilitate discharge and improve a person’s employment opportunities. It is possibly naïve to expect to take someone out of their social, cultural and personal context for a period, offer them treatment and then return them without this process having a negative impact on their social networks, family life or personal functioning.

The traditional approach to acute inpatient care is one that has been dominated by the medical model (McCulloch et al., 2005). Thornicroft & Tansella (2002) describe the progressive closure of asylum beds in favour of acute inpatient units, often located in general hospital premises. This has tended to emphasise the view that admission is primarily for medical treatment or the containment of risk, and that the social determinants of a need for structured 24-hour support are of secondary importance. They highlight the need to shift the focus of care from the hospital, so that this service is perceived as only one element of a broad range of provisions serving a whole community or population. The use of crisis houses has met with success in some areas, but it is a concept that has been ignored by most. As a result, the culture of contemporary acute inpatient units has developed accordingly, with a seemingly strong dependence upon the psychiatrist as expert in matters medical, and ‘responsible’ for risk management. The common concerns of ward rounds and dependency upon medical opinion for discharge or other significant decisions about management are understandable consequences (Onyett et al., 2006).

The development of strengthened community mental health services, particularly in the form of crisis response, home treatment teams and assertive outreach teams, emphasises the fact that disabling psychological distress, of whatever form, is not in itself grounds for admission. Falling admission rates, and the reduction in bed numbers, reflect increasing skills and services available to support those people in distress more appropriately in their own homes. Most importantly, service users, families and carers prefer these services (Onyett et al., 2006; Johnson, 2004).

When admission does become necessary it is commonly for complex social reasons that have made residence in the community temporarily untenable. This requires a complex, multidisciplinary response involving contributions from agencies such as social services that can engage with confused, anxious or threatened relatives, housing agencies, employers and others. As Bridgett and Polak (2003), point out, the admission of a person in acute mental distress can be as much a social as a medical necessity.

These problems are generally beyond the reach of conventional acute inpatient culture and emphasise the need to view admission as part of a continuing journey or pathway that is largely conducted in community settings. Thus, a view of admission as a primarily medical matter becomes outmoded, and so does a view of the consultant psychiatrist as the one holding overall power and responsibility for its conduct (Middleton, 2007).

Since 2003 we have seen developments in the reframing of the relations between professional groups that make up the mental health workforce, resulting in significantly, the publication of New Ways of Working for Psychiatrists (DoH, 2004). Although this is proving helpful in identifying priorities for change among the working practices of community-based psychiatrists, there is little understanding of the challenges faced by the psychiatrist...
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on the inpatient unit. A number of services have endorsed the separation of functional roles between community-based general adult psychiatrists and those focusing upon inpatient services, and more show signs of following this route. This is one model of NWW, which has been found to be effective (Caracciolo & Mohamed, 2007), but is not necessarily appropriate everywhere. However, this type of change in practice alone is not going to address the difficulties of culture and convention that continue to distort acute inpatient services away from holistic, service user centred care, towards the treatment of symptoms and containment of risk (Middleton, 2007).

Key questions are whether services are using the skills and competencies of their staff to best effect (for the service users as opposed to the service). If not, what could be done to change things, and what are the challenges?

New ways of working

The vision and the service imperatives encompassed in the Mental Health National Service Framework (MHNSF) (1999) and the NHS Plan (2000), in the Older Persons and Children's National Service Frameworks (NSF) (1999) and the white paper Our Health, Our Care, Our Say (2006), all reflect the need for staff to review their current practice and services to review their modes of delivery.

New Ways of Working (NWW) is about supporting and enabling consultant psychiatrists (among others) to deliver effective and person-centred care across services for children, adults and older people with mental health problems. This is about big culture change – it is not just tinkering round the edges of service improvement (DoH, 2004).

NWW is not about saving money, releasing resources for other things, nor about undermining the role of the psychiatrist. It is about recognising that we will have increasing difficulty in filling posts – given the high rate of people eligible to retire, fewer school leavers available to enter medical training, despite big increases in training places, and the continued and growing demand for mental health services.

In essence, NWW is about using the skills, knowledge and experience of consultant psychiatrists to best effect by concentrating on service users with the most complex needs, acting as a consultant to multidisciplinary teams, and promoting distributed responsibility and leadership across teams to achieve a cultural shift in services.

It encompasses a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce, offering high quality service. New Ways of Working for Everyone and The Creating Capable Teams Approach (DoH, 2007b) take this concept further in terms of what NWW means for all professions.

In the context of an inpatient service, this raises particular issues. All acute wards contain at least a small number of formally detained service users for whom, at present the consultant psychiatrist holds specific statutory responsibilities. The National Health Service (NHS) measures hospital activity in terms of ‘finished consultant episodes’ (DoH, 2007a). Among coroners, there remains a convention of regarding the doctor as the prime witness in the event of an unusual death. These external, formal givens interact with a number of informal influences that powerfully support and maintain a culture in which many conspire to regard the conduct of an admission as a process ultimately guided and overseen by a responsible medical officer. Important decisions cannot be made without the consultant’s assent, discharge has to be authorised by a doctor, and of course, the consultant in turn is caused to assume a position of power and authority. However, the new ways of working initiative has important implications for other professionals because the assumption that the responsibility for giving information to the coroner is changing. New ways of working means that the evidence is likely to be provided by other professionals holding autonomous responsibility for the case (Royal College of Psychiatrists, 2006a).

Recruitment and retention of inpatient staff and new ways of working

It is acknowledged that staffing problems exist within acute inpatient services. This has been attributed to complex factors including inadequate clinical supervision and leadership, excessive paperwork and perceptions of a ‘blame culture’ in the NHS. All of these factors have affected the morale and motivation of inpatient staff. The inadequacy of educational and training opportunities, which provide inpatient nurses with the knowledge and skills to work effectively in these settings have been highlighted (DoH, 1999).

NWW offers all inpatient staff the opportunity to develop their interests and skills for the benefit of service users. If consultants’ caseloads reduce, they will be able to
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form relationships with service users who require their specific competencies. This will mean that ward nursing regimes could shift from containment towards the therapeutic role that service users desire, with the consultant adopting a truly consultative role. This shift in emphasis in the consultant’s role produces a need for a concomitant change in the rest of the multidisciplinary team. As the consultant moves from a position of overall responsibility for inpatients that are perhaps seen only once a week to a more intensive relationship with smaller groups, this provides the other members of the team with the opportunity to develop and utilise their particular interests and skills to best effect. Thus, they are not confined to the specific remit for which they were originally educated and can become experts in their own field with the doctor taking on a strictly consultative role (DoH, 2005b).

In order for this cultural shift to occur, all staff who work in acute inpatient care must have access to education and training. To be meaningful, this would mean carrying out a systematic training needs analysis with existing staff, to identify existing expertise. This would need to be directly linked to an analysis of the needs of service users to identify gaps in skills and competencies. The creating capable teams approach (CCT) (DoH, 2007b) is designed to help multidisciplinary teams to make a more detailed and systematic review of their function, based on the needs and express wishes of service users and carers and the current and future skills of staff, resulting in a team workforce action plan.

Staff, of all disciplines, who work with acute inpatients, have a great desire to help and support people in their care and use the skills that they have to best effect. There is evidence that complex skills, for example cognitive behaviour therapy (CBT) and psychosocial interventions (PSI) can be used effectively in an inpatient setting (Baguley & Baguley 2002; Gournay 2004; Baguley & Dulson, 2004).

Perhaps most importantly, this cultural shift requires that all disciplines embrace a bio-psychosocial model of mental health in understanding the development and maintenance of an individual’s problem. This facilitates the integration of both psychological and social interventions. In this respect, the contribution of social workers to the work of the team is vitally important. Inpatient services have been culturally dominated by the medical model, and social work knowledge, skills and values are intrinsic to the reform and progress of inpatient services. Psychiatrists’ training increasingly emphasises a consideration of social issues, but the full integration of health and social care factors requires a significant shift in the in patient culture. The effective reintegration of service users into the community requires that health and social care disciplines adopt a holistic perspective. The role of psychiatrists is central to this and it is necessary for social workers to adopt a more high profile leadership and consultative position within multidisciplinary teams (DoH, 2005b).

Discussion

Acute in-patient services have an important role to play in the care of people with mental health problems. The reduction in the number of available beds has led to a ‘raising of the threshold’ for admission and, in turn, led to increasing pressure on all staff groups. More importantly, this has also led to service users feeling frightened, undervalued and unsupported (Muijen, 2002).

It is evident that a whole system shift in the culture is required within inpatient services if they are to keep pace with other service developments. Without this change, service users will continue to receive fragmented provision in which the traditional inpatient service is divorced from that in the community. The delivery of effective person centred care requires support for system change from all acute inpatient staff. It is not enough for psychiatrists to embrace change in the ways in which they practice and manage their work. Role changes must also extend to other disciplines and this involves a move away from traditional models of tasks and responsibilities.

Nurses conduct their own risk assessments and formulate care plans. These are concerned with the day-to-day care of service users and may include, for example, whether the person should bathe unsupervised. Other decisions about observation leave or discharge from hospital is usually regarded as the consultant’s responsibility or, on occasion, the junior doctors. Consequently, consultants are perceived by other disciplines and by service users as those who make the important decisions, usually during the ward round, and as holding the balance of power (Alexander, 2006). This restricts the development of NWW and reinforces the status quo between consultants and other disciplines. It
also allows other disciplines to avoid taking responsibilities, which might involve increased contact with service users in order to elicit information other than behavioural observations.

Cross-disciplinary issues and resultant role changes must be addressed so that the often complex needs of service users are managed appropriately, enabling discharge as quickly as possible from hospital. The service user should receive care/therapy from the most appropriate worker based on the ability of the workers expertise, knowledge and ability to engage with the person. This may involve blurring of professional boundaries, which needs to be managed effectively through teamwork and clinical supervision in NWW (DoH, 2005b). The threshold of risk for admission and discharge is often influenced by the availability of beds. If the complex decisions involved are largely placed upon consultant psychiatrists shoulders, they cannot utilise their skills, knowledge and experience to best effect (Williams & Cormac, 2007). Furthermore, service users may be restricted unnecessarily and discharges delayed causing a bottleneck in the acute services system as a whole.

The negative reports from service users about nursing attitudes and shortages in acute inpatient care may be viewed from a hierarchical perspective in which nurses feel disempowered by the inpatient system. The nursing duty of care embraces safety and therapy. However, within traditional services, nurses are preoccupied with risk assessment and containment. A large element of the nursing role involves servicing consultants’ ward rounds and implementing the decisions that are made (Alexander, 2006). The NWW approach provides opportunities for nurses and others to be equal members of multidisciplinary teams. For this to occur they, and other members of these teams, must be prepared to accept that responsibilities are distributed among those who provide input into decision-making and do not rest with the consultant psychiatrist alone.

Arguably, hospital care should be designated as a speciality with specific training needs. Nevertheless, acute care should be perceived as part of the spectrum of mental health provision incorporating self-management, primary care and community services. A whole systems approach to training might provide service users with a biopsychosocial approach and promote a better understanding between hospital and community staff of work in diverse settings.

Working on the wards may be less attractive to some NHS employees, than modern high-status community services, which may provide more opportunities in terms of higher grades and salaries (Muijen, 2002). Less disparity between the pay of psychiatrists and other disciplines might have an impact on the perception that the highest paid members of the team should also be the most accountable.

Decisions about service users being discharged or going on leave are often confounded by events outside of the control of those working in acute inpatient care. Lack of suitable living accommodation is probably the most obvious cause of extended stays in hospital, but there are others, for example a lack of community support at the level needed, financial problems or problems with more informal (but vitally important) support networks concerning families and carers (Glasby & Lester, 2004).

The literature on hospital discharge indicates that health and social care professionals encounter difficulties in working together effectively. This failure may arise from conflicting perceptions of good practice. On the one hand, the hospital system focuses on a rapid turnover of service users. On the other, the social model aims to help people, who may be facing major life changes, make long-term decisions, which emphasise choice and empowerment. These could be conceptualised as a resource management model that might be described as user-centred; successful discharge requires an integration of both perspectives. This requires a substantial cultural shift in the acute hospital sector and the development of a more holistic approach towards the care of the person. However, the role of professionals exists within an organisational framework that is influenced by structural barriers to progress in joint working such as access to pooled budgets (Glasby, 2004). The complete integration of health and social issues demands a significant shift in the guiding principles and day-to-day practice of services. It is acknowledged that psychiatrists have a major role to play in breaking the cycle of exclusion experienced by service users (DoH, 2005b). In 2004, MIND expressed concern that social care services for mental health service users were under funded and dwarfed by clinical care and priorities. The contribution and leadership of social workers to inpatient multidisciplinary teams and hospital services is vital. Aspects of social theory and care are now embedded in the daily work of community NHS employees, but acute inpatient services still have much to learn from social work expertise (Young, 2007).
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Despite these confounding factors, there are changes that can be made to acute inpatient services that involve not just psychiatrists letting go of responsibility, but other disciplines taking it. A first positive step would be to implement the care programme approach (CPA) in a meaningful way; this would involve each person receiving training in CPA, clarity around the role of the care coordinator and a willingness to engage in the process (NIMHE, 2007). The evidence shows that service users who are involved in their own care planning are more satisfied with the services they receive, but that currently many service users and carers are not significantly involved. Commissioners and practitioners have their own views about service provision, care and treatment. Service user empowerment demands adequate financial resources and positive input from professional groups. This means that professionals may have to relinquish some of their power in collaborative working (SCMH, 2007). The CPA process should support people to find out more information before agreeing about how their assessed needs should be met, and direct payments may be an important tool in the promotion of social inclusion and recovery (DoH, 2006).

Another important driver in cultural change is the adoption of the 10 Essential Shared Capabilities (NIMHE, 2004). These are particularly relevant to new ways of working in acute care. The emphasis on the importance of working in partnership and respecting diversity not only in relation to service users and carers, but also with colleagues has important implications for multidisciplinary teams. Making a difference refers to the capability of offering excellent, evidence-based, values-centred health and social care interventions to meet the needs and wishes of service users, their families and carers. The promotion of safety and positive risk taking involves handling the conflicts engendered by the need for empowerment, and the requirement to confront possible risks to service users and others. Providing service user-centred care involves taking the perspective of service users and carers in setting care objectives. This capability places demands on professionals to find ways of delivering these aims and of clarifying the responsibilities of those who will provide the help that is required.

The capabilities that all staff should be expected to possess make it incumbent upon those working in acute care to take responsibility for their own practice and to work collaboratively. The effective implementation of the 10 Essential Shared Capabilities could cause a cultural shift towards choice, person-centred care and health promotion. They have important implications for the education and training of all staff who work in mental health services. These capabilities also involve accountability for one’s own practice, and a requirement to share and accept responsibility for decisions that have traditionally been borne by consultant psychiatrists.

If a cultural shift is to occur, then it is equally clear that services need to be organised in such a way that mental health workers are allowed to use the expertise they have to best effect (Baguley et al, 2000). Organisational issues at the highest level often militate against change; the requirements of the Mental Health Act, the beliefs and behaviour of coroners, and the methodology for counting consultant activity through the NHS and Department of Health all conspire to make change more challenging.

We have to acknowledge that meaningful change is difficult to achieve, particularly in a large organisation like the NHS and across such a diverse range of professional groups. If we really do have the needs of service users and their families and carers as the main focus for our activities, then change we must: go on you know you want to – it’s not as difficult as you think!

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