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New ways of working in the North Yorkshire Dales

Developing new ways of working for consultant psychiatrists can be done differently depending on the consultants concerned. A group of consultants in rural North Yorkshire made some changes in their working patterns resulting in benefits to them, their teams and their patients. Close working relationships between managers and clinicians were the key to facilitating these changes.

The role of the consultant psychiatrist is changing. This is against a background of issues which have developed over the past decade. The high vacancy rate for consultant posts and the excessive working hours of many consultants have led to dissatisfaction with current arrangements from psychiatrists, other mental health professionals and patients; many psychiatrists feel overwhelmed by work and dissatisfied with their clinical input into community mental health teams (CMHTs). This led the Royal College of Psychiatrists and the National Institute for Mental Health in England (NIMHE) to form a National Steering Group to explore and review the role of psychiatrists and their interface with other professionals in providing mental healthcare. As part of this, conferences were held in March and April 2003 which explored these issues. These were supported by the Royal College of Psychiatrists, the Modernisation Agency, NIMHE, the Department of Health and the British Medical Association, and the results were published by the National Working Group on New Roles for Psychiatrists (2004). Also in 2004 the National Steering Group on New Ways of Working for Psychiatrists published their interim report (National Steering Group, 2004).

Yorkshire has particular difficulties in the recruitment of consultant psychiatrists, with currently approximately 24% of posts vacant. This is not reflected in the North Yorkshire Dales area covered by Hambleton and Richmondshire Primary Care Trust, which provides the mental health service. This service has a less than orthodox background. Mental health services developed in 1987 with the closure of the North Yorkshire mental hospitals in York. Prior to local in-patient provision a community service was developed. This was strongly supported by the general practitioners within the area, and indeed the service developed strong links with primary care (Simpson, 1989, 1991). Over the years consultants were attracted to the community-oriented rural service and so were appointed with this interest. Specialist services developed later, so that old age psychiatry has only been separated from general adult psychiatry in recent years. As well as the close links with general practitioners, there has been a history of close links with patients in planning and delivering services. All the consultant posts (7.5 whole-time equivalents) are filled.

Some of the consultants were involved in the initial survey by Kennedy & Griffiths (2000), which led to reflection on the working role of psychiatrists within the trust and the realisation that as the service had developed the consultants had become involved in treating an increasing number of patients through the CMHTs, day hospitals and wards, as well as being available directly to general practitioners for crises. With the large geographical area covered and the increasing case-loads, it became apparent that the current arrangements were unsustainable.

Actions taken

The doctors had been closely involved in developmental issues within the trust and so had a history of close working with managers. This included work on the National Service Framework, as well as developing appropriate models of services for a rural area by the fidelity and flexibility arrangements (National Institute for Mental Health in England, 2003).

A meeting was held between senior managers and consultant psychiatrists to look at the current arrangements, and from this a number of actions were developed. It was agreed that the consultant psychiatrists should be able to have more time available to see the more severely ill patients and more time available for discussing patients with other team members. Most patients were therefore allocated to other team members who could easily access the consultant for advice or further clinical opinions. This was a smooth transition and a natural progression of the role of the consultants, reinforcing their role as clinical leaders.

Consultant contract

As part of negotiations on the new consultant contract, the consultants completed a workload diary. This

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highlighted the excessive hours being worked owing to long working days and on-call commitments – hours that remained high even with the consultants taking a half-day each week. In negotiation between the Associate Medical Director and the consultants, it was agreed that instead of each consultant being paid for the amount of programmed activities for their individual workload, the consultants' working hours were pooled and then each consultant was paid for the same amount of programmed activities but to a level slightly below the mean. This resulted in the consultants having management support to reduce their hours while removing any financial incentive to work longer. It reinforced the concept of consultants working together as a team. All parties were happy with this agreement.

Job planning and appraisal

The Associate Medical Director was involved with job planning and appraisal from the start. It was agreed that within the job plan the consultants should aim at having fixed activities for only half of each day so that they would be available to respond to emergencies. It was also agreed that they would reduce their workload by reviewing their case lists to identify patients who could be assigned to other team members. The aim was to provide more time for the consultants to spend with more challenging patients and to be available for consultation by the rest of the team. In addition, although no specific crisis team was developed within the area, an arrangement whereby crises were attended within 4 h by a non-medical member of the team initially helped to free up time for the consultants to fulfil their role as clinical leaders, be available for the team and to see patients in crisis. Meanwhile, all consultants were offered extra training in management and leadership skills. It was also stressed that the consultants should not normally be designated as care coordinator for any patient on the enhanced
care programme approach. This was audited each month, as was the case-load of each consultant, with the information fed back to the consultants themselves.

Team managers

The team managers were responsible for all the staff in the CMHTs and so were vital to any change in working practices. They also took care of the practical running of the team (e.g. bringing referral letters or chairing meetings), leaving the consultant free to lead on clinical matters. They met with the Associate Medical Director regularly and a list of actions was developed in order to change the culture of the community teams and the role of the consultant in line with the agreed aims. Part of this was helping the consultants present to their individual teams their current roles and the changes that were being made. This enabled the team members to see the benefits of the changes for themselves and for patients. In addition, the team managers were able to support all other team members in developing the crisis service and in not allocating too many patients to the consultants at the team meetings. Patients were consulted and were happy with these developments, as they valued the availability of consultants in a crisis over long-term regular appointments in clinics.

Results

As a result of these changes, we were able to monitor the decrease in case-load for each individual consultant over time. Through the job planning and appraisal system it became apparent that the hours worked and pressure upon the consultants had indeed decreased, and the other team members were happy with the changes.

Conclusions

The changes required in the Hambleton and Richmondshire Primary Care Trust to the working practices of consultant psychiatrists were not as great as in other trusts. Indeed, all the posts were filled and the morale of the consultant psychiatrists had always been reasonably high. However, the problems with hours worked and numbers of patients on case-loads were becoming an issue. By developing a plan to change the role of consultant psychiatrists within the CMHTs and with the doctors and managers working together in a manner facilitated by the job planning process, these problems were able to be resolved.

Declaration of interest

None.

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