

Responsibility and Accountability

Moving on for New Ways of Working to a creative, capable workforce

Best practice guidance



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Best practice guidance



The National Mental Health Development Unit, launched in April 2009 (and incorporating a number of former NIMHE programmes), provides national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services. It is funded by both the Department of Health and the NHS.

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“We expect everyone responsible for our son’s care to be able to make the right decisions that are genuinely in his best interests. Positive risk taking that maintains hope and helps move towards recovery alongside good communication should be at the heart of any mental health team. We hope this document will help everyone to work together to ensure that this happens.”

Two carers who have become service users

1 Executive summary

- 1.1 ‘Who is responsible for...?’ and ‘Am I responsible for...?’ are questions that arise frequently in mental health care. As questions, they seem straightforward enough, but further consideration reveals the complexity that can underlie them. Perhaps the questioner is just filling an acceptable gap in knowledge, or checking their understanding, but the question can also have negative connotations, such as:
- confusion – nobody is clear who is responsible for what, and therefore who is going to take what action
 - fear – of having to take on responsibilities for which one is not properly equipped
 - anxiety – at having to be accountable for the discharge of the responsibility
 - concern – at the possibility of having to be accountable, without having discharged the responsibility oneself
 - anger – at having to take on responsibility that one feels should be discharged by someone else for a variety of reasons
 - frustration – trying to find out who is responsible in order to get action taken, make a complaint or obtain redress
 - ignorance – of the way in which responsibilities have been delegated or distributed and therefore who should be discharging them
 - obfuscation – when debates about who is responsible result in, or are used to explain, delays and inaction.
- 1.2 New Ways of Working (NWW) is about the development and maintenance of multi-disciplinary creative, capable teams working with efficient processes to deliver person-centred care, and it has brought questions relating to responsibility and accountability to the fore, for a variety of reasons:
- The degree of multi-disciplinary working required to develop and implement NWW has revealed that professions often understand little about one another’s roles and responsibilities, in particular their regulation.
 - Practitioners, managers, service users and carers have had to understand the responsibilities of colleagues undertaking new roles in mental health care, and how those roles mesh with the others in the team and across the system.
 - The possibilities for extending roles beyond the scope of traditional practice have resulted in more areas of overlapping skills.
 - The emphasis on effective teamworking and distribution of responsibility has necessitated a re-evaluation of notions of responsibility relating to particular roles or professions.

- Responsibilities may never have been clear, and new staff or new interfaces with other teams have made this apparent.
- Greater service user and carer involvement in service redesign and improvement initiatives may lead to greater challenges to long-held assumptions.

1.3 This document is our response to the challenge of how to turn a question that is so often negatively laden into one that provides an opportunity to add clarity and solve problems, in order to provide service users and carers with a more seamless, logical, personalised and timely pathway through care. It provides a resource that can be used to support local discussion and decision making, and includes the following:

- a summary of what NWW should be about, and what working in a team where responsibility is distributed really means. It is important to emphasise that the team decision making that results is advocated to improve the quality of the evidence base for decisions, as well as to ensure ownership of them once made: it encourages responsibility rather than diffusing or dismissing it
- definitions and an interpretation of some of the terms that are used and misused in the discussion of these issues, including practitioners', employers', medical and clinical responsibility, the delegation, distribution and transfer of responsibility, the different types of supervision and the relationships therein, and leadership and management
- principles for practitioners to bear in mind in decision making, record keeping, information sharing and the provision of advice
- an outline of responsibilities enshrined in law, those forming organisational policy, and the guidance from professional organisations and regulators
- a section explaining the principles of indemnity
- an exploration of the relevance of the subject matter to the development of mental health policy and practice.

1.4 Many people and organisations have been involved in the development of this document over a 16-month period; they are acknowledged at the end. Their objectives were to provide clarification, guidance, synthesis and interpretation in this complex area, in order to achieve the aspirations of the carers who wrote the frontispiece – a culture of positive risk taking, where practitioners do not hide behind issues of responsibility as an excuse for not doing the right thing; a creative, capable workforce where responsibilities are aligned with skills and competences; and a system where team decision making, with the communication required to achieve it safely and effectively, is seen as a strength.

2 Introduction

What is this document about?

- 2.1 This document aims to clarify thinking about responsibility and accountability for staff, service users and carers.¹ It has been developed by the National Institute for Mental Health in England (NIMHE) National Workforce Programme, which produces guidance to aid the implementation of more flexible workforce planning and practice.
- 2.2 It is a **guidance document**, which discusses the implications of working in new ways, and it brings together information from a variety of sources to inform the guidance. It aims to be **permissive**, supporting practitioners, teams and organisations to do the right thing for people with mental health problems and for the whole population.
- 2.3 It provides a **synthesis and interpretation** of current guidance and regulation, in the context of workforce modernisation. It is therefore aligned with extant guidance from regulators, employers, professional organisations and trade unions, and mental health law, all of which is referenced throughout.

Why is guidance necessary?

- 2.4 The mental health workforce has undergone significant transformation in recent years, with **teamwork** being central to the delivery of a modern, flexible mental health service, combined with service users and carers taking a more central role in their care and treatment.
- 2.5 As a result, the time is right to re-appraise commonly held assumptions about who is responsible for what, the circumstances in which responsibilities can be distributed or delegated, and how accountabilities reflect this.
- 2.6 This guidance supports practitioners to take individual responsibility for the tasks they perform, commensurate with their capabilities and in accordance with the guidance provided by those to whom they are accountable. Taking individual responsibility and working effectively as a member of a multi-disciplinary team are not in conflict. NWW is not about diffusion or dilution of responsibility; responsibilities need to be clarified because there are now more types of practitioner in the workforce, and because job titles alone are not always a good guide to expectations and responsibilities.
- 2.7 This guidance is therefore about supporting and promoting good practice. It aims to help practitioners and their employers to avoid the problems that can arise when:
 - responsibilities and accountability are poorly defined, or are not understood by all the members of the team

¹ For clarity, providers of mental health care are referred to as 'staff' or 'practitioners' in this document, with the term 'employee' used in sections pertaining to the relationship to the employer; those receiving care are referred to as 'service users' and family or friends in supportive roles are referred to as 'carers'. Where other terms are used in the parent material, for example 'patient', those terms are retained for consistency with the original.

- responsibilities have not been properly exercised
 - practitioners are discouraged from taking initiative and responsibility by the system within which they work
 - employers demand that practitioners assume responsibilities that they are not qualified or competent to undertake
 - practitioners themselves assume such responsibilities, for example seeking to control the work of others where they have no formal accountability for their work
 - lines of accountability conflict
 - allocated responsibilities cannot be executed because of a lack of resources, or a lack of the appropriate underpinning systems and processes
 - allocated responsibilities conflict with the practitioner's own personal values and the values embodied in their role as a professional practitioner.
- 2.8 Good practice encourages learning from mistakes, and the openness and readiness to change that is part of that. However, learning organisations will encourage debate about these issues whether or not there are any specific problems to resolve. It is hoped that this guidance will support them to do this.
- 2.9 A word of encouragement: the issues covered here are many and complex so, inevitably, the guidance is not a five-minute read. However, the reader is urged to persevere, because it is vital to understand the context and issues if staff and organisations are to feel confident in addressing issues of responsibility and accountability in order to make care clearer and safer.

Who is this guidance for?

- 2.10 This document is relevant to everyone who provides or receives mental health care in England, although the principles will be more widely applicable.
- 2.11 While there may be particular considerations for specific services, eg those working with people detained under the Mental Health Act 1983 (as amended by the Mental Health Act 2007), it is designed to be applicable to general and specialist services working with people of all ages and with all manifestations of mental disorder.
- 2.12 Clarity about how responsibilities are determined and their limits is important for service users and their families. Hopefully, providing that clarity locally can help them to access the most appropriate help when they need it, improve overall satisfaction with services and reduce complaints. Organisations could consider using this document to develop information for service users, carers and staff locally.
- 2.13 This document is designed to be useful to trainees and their trainers. It supports the development of opportunities for multi-professional training and continuing professional development by bringing together information from different professional perspectives and identifying their common aims.
- 2.14 The material has been written with a view to supporting team and individual practitioner development, and may be useful in supervision and appraisal.

How has this guidance been developed?

- 2.15 Issues relating to responsibility and accountability have been raised throughout the development of NWW. In 2003, following the first national NWW conferences, Avon and Wiltshire Mental Health Partnership Trust produced its Board-approved *Trust Guidance on the Role of the Consultant Psychiatrist*, which interpreted the national statute and guidance that was extant at the time. This document was subsequently recommended for use by other trusts in *New Ways of Working for Psychiatrists* (Final Report)² and many either used it or adapted it for their own needs. Then in 2005, as a result of work led by the Deputy National Director for Mental Health, Hugh Griffiths, the General Medical Council (GMC) supplemented their guidance for doctors (see GMC section in Appendix A) with specific guidance for psychiatrists.
- 2.16 As the development of NWW broadened to include all staff,³ it became clear that guidance on issues of responsibility that could be used by everyone, across service settings, was also needed.
- 2.17 A National Development Workshop was held in London in November 2007 to start this work, and the National Steering Group for NWW then established a subgroup, with the involvement of professional bodies, to produce this guidance.
- 2.18 Some of the issues raised in the workshop will be for local determination (for example, the distribution of responsibilities between different providers inputting into the same care pathway) and answers will vary according to the way services are organised (for example, the responsibility for monitoring physical health), but many were of general applicability. The most common related to:
- different definitions and the potential for misunderstandings in the use of language
 - how the responsibilities of non-professionally regulated workers are determined
 - how responsibilities of individuals working at different levels in an organisation are linked together
 - whether there were instances in which one type of responsibility could ‘trump’ another.
- 2.19 A final workshop was held in February 2009, involving professional regulators, to test out the utility of the guidance using real case examples, and to finalise it. The contributors to the development of the guidance and the organisations they represent are listed at the end of this document.

² *New Ways of Working for Psychiatrists; Enhancing effective, person-centred services through new ways of working in multi-disciplinary and multi-agency contexts.* Appendices of the Final Report: Appendix 5a www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122342

³ *New Ways of Working for Everyone* www.healthcareworkforce.nhs.uk/resource_library/latest_resources/mental_health:_new_ways_of_working_for_everyone.html

3 Summary of New Ways of Working

- 3.1 The development of NWW has stimulated debate about responsibility issues. NWW is about creating and sustaining a capable, flexible workforce to respond to service user and carer needs effectively and efficiently. It is not about the adoption of particular models of service delivery. The principles are described below.
- 3.2 NWW sees the fundamental unit of service delivery as the team, rather than lone professionals. Within the team, **responsibility is distributed**. This does not mean that responsibility is diffused or evaded. Practitioners take responsibility for the care and the advice that they provide. Those in receipt of advice are responsible for what they do with it. Decisions will be made by practitioners with the service user, but the model encourages team discussion of the more significant decisions, where more views on the issue will contribute to the safety and robustness of the ensuing plan. If one member of the team needs to take responsibility for the final decision, then who that is should be explicit within the team. The team has collective responsibility to come to a consensus on important decisions, but in the rare cases where this is not possible, someone will need to be designated as the final arbiter of the decision. Senior practitioners are likely to be the people taking this role.

Excerpt from Plymouth Primary Care Trust (PCT) Positive Risk Management Policy

Work collaboratively to share information, improve decisions and share responsibility.

Risk management plans should be developed by individual practitioners, and by multi-disciplinary and multi-agency teams in an open, democratic and transparent culture that embraces reflective practice and ensures shared responsibility.

Working together is a critical part of risk management and can help to ensure:

- that key information is shared to ensure safety
- that different perspectives can be brought together to make the best decisions
- that responsibility is appropriately shared between teams, practitioners and service users.

In low-complexity, low-risk cases, practitioners working alone with service users can make effective risk management plans. However, in many situations the best risk assessments and most effective management plans are developed by pairs of practitioners or teams working in consultation with service users and carers.

- 3.3 Service users are seen by the most appropriate person in the team to meet their needs. Thus in a NWW team, the consultant psychiatrist no longer has a large caseload of patients to be seen routinely in outpatient clinics a few times a year, often for many years. The time freed up is used to respond in a flexible and timely manner as needed to help manage the care of those with more complex needs. New roles, such as assistant practitioners or support, time and recovery (STR) workers, can

help to free up the time of professionally qualified staff to deliver more evidence-based therapies and interventions.

Excerpt from Norfolk and Waveney Mental Health Foundation Trust information for service users and carers about non-medical prescribing

<p>Introduction Non-medical prescribers can now prescribe your medicines. This leaflet explains how this works.</p> <p>There are 2 types of non-medical prescribers:</p> <ul style="list-style-type: none"> • Supplementary prescribers • Independent prescribers <p>Supplementary Prescribers These are staff allowed to prescribe medicines for a condition that has already been diagnosed by a Senior Doctor. There should be an agreement between you, the prescriber and your Doctor for your treatment over a defined period of time. During this time the non-medical prescriber can write prescriptions for you as described in the plan.</p> <p>It is your choice to decide whether you agree to supplementary prescribing. If you do not agree, your treatment will be prescribed in the traditional manner.</p>	<p>Independent prescribers. These are staff who can prescribe treatment for you without an agreement with a Senior Doctor.</p> <p>Why introduce supplementary prescribing?</p> <p>The potential benefits include:</p> <ul style="list-style-type: none"> • Allowing service users much quicker and more effective access to medication • Increasing service users' choice • Providing services more efficiently • Making better use of nurses' and pharmacists's skills & knowledge <p>What can a nurse or pharmacist prescribe? Only the medicines that you, your Doctor and nurse/pharmacist have agreed that they can prescribe.</p>	<p>What does this mean for me? This means that medication changes can be made quickly without having to wait for a doctor. You will not have to wait for things such as leave prescriptions to be written or making an extra appointment to see your Doctor.</p> <p>I thought only Doctors could prescribe? Only nurses and pharmacists who have undertaken special training can prescribe medicines in certain circumstances.</p> <p>What if I do not want a certain nurse or pharmacist to prescribe for me? You have to be in full agreement with the plan. If there is a prescriber you do not want to prescribe for you, you should inform your Doctor.</p> <p>Can I stop it at anytime? Yes, if you no longer wish a non-medical prescriber to prescribe for you, you should inform them and your Doctor and it will stop immediately and your Doctor will prescribe for you.</p>

3.4 **Process redesign** is carried out wherever processes are found to be inefficient, for example they are taking too long or involving needless duplication. The time saved is re-invested in clinical care. For example, a multi-disciplinary assessment can actually save time, because one team member can record the information while the second gathers it, and decision making is more robust, obviating the need for lengthy feedback at team meetings. The time saved is re-invested in clinical care, for example to ensure that nobody has to wait for an assessment in the first place.

3.5 **Workforce planning** ensures that the skill profile of the team matches the needs they have to serve. Opportunities are taken to develop practitioners into enhanced or extended roles, with appropriate training and support, where these can increase the 'fit' between the needs and the skills available.⁴ The Creating Capable Teams Approach (CCTA)⁵ is a tool to create a team-level workforce plan with the involvement of service users and carers.

⁴ www.newwaysofworking.org.uk/PDF/More%20than%20just%20staffing%20numbers.pdf

⁵ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074501

Oxleas Mental Health Foundation Trust – Extending skills to improve access to care

Nurses and occupational therapists have been trained in the safe use of gym equipment to educate service users about healthy lifestyles and tackle the sedentary lifestyle that can become part of life on a ward. Both qualified and unqualified nursing and social care staff have been trained to take bloods.⁶

3.6 The objectives of NWW are to have:

- service users seen in a timely fashion, when needed
- reduction or elimination of ‘routine’ outpatient clinics
- a flexible and coherent approach, so that service users do not find themselves caught between different services for which they do not ‘fit’ the criteria
- an enhanced role for the care co-ordinator where the Care Programme Approach (CPA) is being used, who brings in others to assist with the care plan as required, with better information sharing, so that different professionals can use one another’s assessments
- optimal use of the available technology to improve efficiency
- reasonable caseloads for all, no waiting lists, and good throughput through the team; and appropriate discharge back to primary care, as well as re-referral when needed, are both straightforward and timely processes
- more time available for a holistic approach to care, encompassing all biopsychosocial aspects
- high levels of service user and carer satisfaction, which the team measures and reflects on
- intelligent use of team data to improve performance and outcomes
- intelligent and appropriate communication and information sharing to work in partnership with service users and carers.

In the Leeds Crisis Team, there was limited access to doctors for prescribing, particularly out of hours. Non-medical supplementary prescribers started working in Leeds Partnership Foundation Trust in 2004, and in 2006 the first independent prescribing started. The non-medical independent prescribers on the Crisis Team initially used a limited formulary, which was expanded as their knowledge and experience increased. They have been able to prescribe swiftly for service users in crisis which has helped make home treatment successful and avoided the need for admission.

Contact: Mark.Dodd@leedspft.nhs.uk

“My community psychiatric nurse gave me options... I found everything all right. She has finished seeing me now but I know if I need some extra support I can phone her.”

Service user

⁶An example from NIMHE (2008) *More than just staffing numbers: A workbook for acute care workforce redesign and development.*
www.virtualward.org.uk/silo/files/more-than-staffing-numbers.pdf

4 National guidance

New Ways of Working guidance

- 4.1 In his foreword to *New Ways of Working for Everyone* (2007),⁷ the National Director for Mental Health, Professor Louis Appleby, described the work as ‘groundbreaking’. The work was started in 2003 by the NIMHE and the Royal College of Psychiatrists, and described in an interim report (2004)⁸ and a Final Report (2005).⁹ NWW initially encouraged psychiatrists to review their traditional working practices, and this approach was then extended to the whole workforce, across all sectors, with the involvement of service users and carers integral to the whole process. An implementation Guide to support the strategic implementation of New Ways of Working in trusts was published in October 2007.¹⁰
- 4.2 The CCTA is a five-step approach with a **defined workforce focus**, developed to support the integration of NWW and the new roles into the structures and practices of a multi-disciplinary team, **within existing resources**. It was designed to be used in all areas of mental health, across health and social care, **for all ages**, in statutory, voluntary and private sectors, including in all staff disciplines. A wealth of information relating to CCTA can be found on the NWW website.¹¹

Refocusing the Care Programme Approach

- 4.3 The updated guidance on the CPA, published in 2008¹² after extensive consultation, aims to target CPA more effectively, make it more person-centred and reduce the bureaucracy that has grown up around it. The document emphasises the role of the care co-ordinator in providing the ‘helicopter view’ and navigation through increasingly complex systems. The need for this role is seen as a determinant of the need for formal CPA; where needs are met in a straightforward way, they can be provided by individual practitioners without the need for the formal framework.

⁷ www.newwaysofworking.org.uk/PDF/progressreportpdfapril2007.pdf

⁸ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087352

⁹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122342

¹⁰ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079102

¹¹ www.newwaysofworking.org.uk/content/view/29/440/

¹² www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

5 Policy context

5.1 Guidance on responsibility and accountability issues needs to be aligned with mental health service development, and the wider health and wellbeing agenda. There are many aspects of policy to consider in this regard, including the following:

- The Next Stage Review,¹³ which emphasises throughout the need for patients to have ‘more rights and control over health and care’ in order to ‘take greater responsibility for their own health, and to dedicate their own time, effort and energy to solving their health problems’ (3.25). The Review focuses on outcomes, saying that ‘the new accountability is for the whole patient pathway’ and that clinicians will be ‘held to account for the quality outcomes of the care that they deliver’. The report also says, crucially, that ‘setting NHS staff free from central control requires a new, stronger accountability that is rooted in the people that the NHS is there to serve. It means that the service should look out to patients and the communities they serve not up the line’ (5.7).
- ‘Transforming Social Care’,¹⁴ which describes the vision for development of a personalised approach to the delivery of adult social care, and this commitment is extended to healthcare in the Next Stage Review. New issues of responsibility and accountability will need to be considered as more patients commission their own care.
- The NHS Constitution¹⁵ and the accompanying Statement of NHS Accountability.¹⁶
- The World Class Commissioning¹⁷ programme.
- New Horizons,¹⁸ which outlines the next stage of mental health service reform after the National Service Framework came to an end in 2009, and continues the emphasis on prevention, patient empowerment and quality.
- The National Dementia Strategy,¹⁹ *Living Well with Dementia*, which says that dementia care needs to be the responsibility of the whole health and social care system, not just specialist mental health services for older people. It also says that the separation of ‘functional’ and ‘organic’ services is ‘a false dichotomy’ that risks disadvantaging patients with dementia with complex needs and their carers.
- The final report of the independent Child and Adolescent Mental Health Services (CAMHS) Review,²⁰ which sets out a clear vision for how we can all take responsibility for promoting children’s psychological wellbeing and mental health, and how we can best achieve a step change in the quality and consistency of services at all levels. The Review found that current accountability in CAMHS is ‘diffuse’, with a lack of clarity around lines of accountability, and

¹³ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

¹⁴ www.dh.gov.uk/en/publicationsandstatistics/lettersandcirculars/localauthoritycirculars/dh_081934

¹⁵ www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

¹⁶ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093422

¹⁷ www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm

¹⁸ <http://newhorizons.dh.gov.uk/index.aspx>

¹⁹ www.dh.gov.uk/en/publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058

²⁰ www.dcsf.gov.uk/CAMHSreview/

lacking leadership and effective joint working. In many areas, parents in particular are uncertain about who is responsible for ensuring that their children get the right support. To improve leadership and accountability, there will be a clearer articulation of roles and responsibilities for all relevant people working in children's services at local, regional and national level.

- The Improving Access to Psychological Therapies²¹ programme, which is designed to assist PCTs in ensuring the provision of psychological therapies for the treatment of mild to moderate anxiety and depression as recommended in National Institute for Health and Clinical Excellence (NICE) guidance.^{22,23} Therapies are being provided by staff in new and extended roles in different sectors, and transfer and sharing of responsibilities, and the contractual accountabilities of therapists are some of the issues of relevance that will need to be agreed.

²¹ www.iapt.nhs.uk

²² Anxiety: www.nice.org.uk/Guidance/CG22

²³ Depression: www.nice.org.uk/CG023

6 Responsibilities in principle

6.1 Parts of the section below are based on work carried out collaboratively on NWW for applied psychologists.

Responsibility and accountability

6.2 The terms 'responsibility' and 'accountability' should not be used interchangeably; the following is one of several definitions:

- **Responsibility** (for) can be defined as a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand.
- **Accountability** (to) describes the relationship between that practitioner and the organisation in question. Accountability describes the mechanism by which failure to exercise responsibility may produce sanctions such as warnings, disciplining, suspension, criminal prosecution, or deregistration from professional status. It can be called 'answerability'.

Practitioner responsibilities

6.3 Practitioners within teams may be accountable to different authorities for the discharge of their responsibilities, as follows:

- **Employee responsibilities** are defined by a contract of employment, which usually includes a job description setting out responsibilities in detail. These objectives should be discussed, developed and clarified with the individual's line manager both informally and formally as part of the performance appraisal process. It is important that the employee appreciates the link between their work objectives, those of the team and those of the organisation.
- **Professional responsibilities** are defined by a duty of care to users, professional codes of conduct and, in some cases, state registration and regulation. For staff in training or recently qualified, this includes formal accountability to a professional line manager in a clinical supervisory role. Professionals are required to recognise and observe the limits of their training and competence and satisfy themselves that anyone else to whom they refer is also appropriately qualified and competent.
- **Legal responsibility** (defined by Statute and common law) forms part of professional responsibility and describes the obligation to comply with the law. Where a practitioner is identified as the Responsible Clinician for an individual detained under the Mental Health Act, or works as an Approved Mental Health Professional or Section 12 doctor, they will have additional legal responsibilities.

- 6.4 The aim is to ensure that none of the responsibilities conflict. For example, an employer should not demand that a practitioner assumes responsibilities that they are not qualified or competent to exercise. Similarly, practitioners should not seek to control the work of another where they have no formal accountability for their work.
- 6.5 Values of individuals may vary, but their practice should be informed by expectations expressed by service users and carers, as described in *The Ten Essential Shared Capabilities*.²⁴ Some guidance, for example the British Association of Social Workers Code of Ethics for Social Work,²⁵ also uses the term ‘duty’ when describing the values underpinning ethical practice.

The Ten Essential Shared Capabilities for Mental Health Practice

- Working in partnership
- Respecting diversity
- Practising ethically
- Challenging inequality
- Promoting recovery
- Identifying people’s needs and strengths
- Providing service user centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning

- 6.6 However desirable it is that values held will be appropriate, it is only actions and behaviours that can be assessed and regulated, and for these practitioners are accountable to employers, their professional bodies, people who use their services and the wider public.

Medical responsibility

- 6.7 Historically, a medical practitioner has been deemed to have ‘responsibility’ for a patient at all times, with the term being used without further qualification as to its extent or purpose.
- 6.8 Responsibility has been defined above as relating to the discharge of certain tasks or functions. Therefore, should ‘medical responsibility’ relate to the discharge of those tasks or functions that a doctor is uniquely able to undertake by virtue of their medical training, skills and experience, and registration with the GMC?
- 6.9 The difficulties with this term are then readily apparent, because with the expansion of non-medical professional roles, the ‘unique’ functions of a doctor are more circumscribed than they used to be. Sir John Tooke, in his report on modernising medical careers in 2007,²⁶ called for the profession to

²⁴ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169

²⁵ www.basw.co.uk/Default.aspx?tabid=64

²⁶ www.mmcinquiry.org.uk

define the role of the doctor, but this misses an essential element – when doctors work in partnership with service users and carers, and as part of a team or teams, it surely cannot be for them alone to define. An additional problem is that when responsibilities of consultants are discussed, this refers to all consultant doctors, the majority of whom are working in systems very different to those in mental health. Guidance often appears to have been written with the general hospital-based consultant in mind.

- 6.10 The British Medical Association's *Consultant Handbook* (2005)²⁷ says 'only a consultant or principal in general practice can accept ultimate medical responsibility in NHS units and the development of new working patterns and increased multi-disciplinary working should not alter this basic principle. ... In the case of referral to non-medically qualified health workers, consultants should ensure that such staff are accountable to a statutory regulatory body, and that a medical practitioner retains overall responsibility for the management of the patient.' It goes on to say, 'in order to ensure proper continuity of medical responsibility for patients, the [Central Consultants and Specialists Committee] advises consultants to insist, wherever possible, on referrals coming from a named medical source', but concludes: 'in the day-to-day performance of their duties, consultants will take responsibility for their own practice.' It is unclear what the term 'ultimate medical responsibility' is supposed to mean here; is it a tautological term for the share of the responsibility taken by the doctor, or does it imply taking responsibility for aspects of care being provided for others? The second part of the statement, on referral, seems out of step with current practice as it implies that doctors should be in charge of all referrals within and between teams and services.
- 6.11 The Academy of Medical Royal Colleges has issued a recent Consensus Statement on the Role of the Doctor,²⁸ which says: 'Doctors alone amongst healthcare professionals must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty, drawing on their scientific knowledge and well developed clinical judgement.' Setting aside the question of whether in mental health care this role would always be taken by a doctor, the statement of what the responsibility is about is clearer than in the BMA statement above. It is consistent with the description of team decision making and distributed responsibility in section 3.2, emphasising the point that there will be times when one person in the team needs to take a difficult decision, and this is likely to be related to situations of complexity or uncertainty.
- 6.12 The statement then goes on to make a slightly different point, saying: 'As the critical decision maker with responsibility for significant health resources the doctor must be capable of both management and leadership and of taking ultimate responsibility for clinical decisions.' This point is emphasising the importance of the clinical voice in decisions over resources (for example staff time, or the cost of drugs or procedures). It is also worth noting that both these statements say that the doctor 'must be capable' of taking these responsibilities, which is unlikely to be contentious. They do not say that this level of 'ultimate decision making' will be required routinely.

²⁷ www.bma.org.uk/images/consultantshandbook2009_tcm41-188576.pdf

²⁸ www.aomrc.org.uk/aomrc/admin/news/docs/Final%20consensus%20statement%20on%20the%20Role%20of%20the%20Doctor.pdf

- 6.13 The Hospital Consultants and Specialists Association, in a recent position statement,²⁹ says: ‘In particular the importance of a named consultant being responsible for each episode of care was re-iterated. However it must be emphasised that these statements are complementary to the duties of all doctors as required by the GMC... The Hospital Consultant must have the leadership skills, knowledge and expertise to be personally responsible for the delivery of timely diagnosis and appropriate treatment to individual patients and this responsibility should be ongoing while the patient remains under his/her care.’ This statement, as would be reasonable from an organisation originally focusing on hospital doctors, seems to fit best with a description of a hospital episode of care, but has not taken account of the recent changes to the Mental Health Act which clarify in law that a non-medical clinician can take this role if they are the designated Responsible Clinician. However, it does clarify the importance of abiding by GMC guidance, and later it clarifies the role of the employer, when it proposes that ‘On appointment an individual consultant will agree with the employing Trust/Clinical Director the areas of expertise and responsibilities which are currently within his/her competence.’
- 6.14 Disentangling what is meant by medical responsibility is therefore difficult, and made more so because it can be used ‘politically’, being associated with status, influence and power on the one hand, and used by non-doctors on the other to avoid taking appropriate responsibility. It has also been used pragmatically by those outside the team, including primary care, service users and carers, as a way of trying to navigate a complex system and identify a named person whom it is assumed can ‘get things done’ or ‘give me an answer’.
- 6.15 Nowadays, the added political dimension is the concern among some doctors that a loss of the ‘primacy’ of medical responsibility, and the reduction of the number of unique attributes of the doctor’s role, will contribute to the undermining of, and eventually the demise of, the profession. Alongside that, however, are concerns that reductions in training length and hours will result in new consultants being ill-equipped to take on the full raft of their responsibilities, however defined, and concerns about being held responsible for events outside one’s control in the event of problems. Medicine, and psychiatry, therefore finds itself in a dilemma about whether to try and carve out clear and broad responsibilities, which may safeguard its position but also bring real risks of unfeasible jobs and public censure when things go wrong, or to share the responsibilities, which may undermine the security of the position of the doctor. What is the way forward?
- 6.16 Firstly, there are some responsibilities that can only be legally carried out by (appropriately trained) doctors. Medical recommendations under the Mental Health Act are carried out by doctors, and only doctors are eligible to be mental health assessors under the Deprivation of Liberty Safeguards, which supplement the Mental Capacity Act 2005 (see legal section on page 31). The certification of death is still a medical task.
- 6.17 Secondly, there are areas of practice where doctors will take the lead in most cases by virtue of their training, knowledge and skills, for example in diagnosis and in determining the relationship between physical and mental disorders and the appropriate physical tests to support diagnosis and management.

²⁹ https://secure.hcsa.com/pix/Whats_in_a_Name.pdf

- 6.18 Thirdly, there are areas where doctors will take the lead in many cases, for example in devising appropriate management plans in complex cases (some of which will relate to diagnostic uncertainty or the relationship between symptoms of physical and mental disorder). This will continue to be an important role for doctors, but not a unique one, as evidenced, for example, by the new role of Responsible Clinician in the Mental Health Act 2007. Such management plans are likely to have a number of components, with responsibility for delivering them distributed accordingly among the team.
- 6.19 Fourthly, there are other areas where the medical practitioner may have a distinctive contribution to make alongside those of colleagues from other professions. These are more appropriately termed clinical responsibilities, discussed below. The assessment of clinical risk would be an example. Such responsibilities are taken by appropriately trained and qualified staff, and delegated to those who are in training.
- 6.20 Finally, the extent of experience and the possession of the appropriate aptitudes, knowledge and skills by those of all professions will determine suitability for broader roles and the responsibilities they bring, for example in clinical leadership (see below), management, service development, teaching and training, and research.
- 6.21 It is important to remember that in mental health we are going further in trying to tease out these issues than has been the case elsewhere, which is why it can seem so complex and contradictory. Many people will recognise the scenario of being admitted to a general hospital ‘under’ a particular consultant but not having any contact with that consultant during their episode of care. Doctors, patients and non-medical staff will all see the potential implications for responsibility and accountability issues. The purpose of this guidance is to help locate responsibility appropriately and to contribute to depoliticising it as an issue.
- 6.22 Whatever the differences in emphasis or semantics in the quotations from guidance given above, they all advise doctors of their overriding responsibility to abide by the guidance issued by their regulator, the GMC. This is additionally helpful for psychiatrists because work done collaboratively between the Department of Health, the NWP, the NWW team, the Royal College of Psychiatrists and the GMC in 2005 led to the GMC issuing a clarification of its guidance on ‘Good Medical Practice’, which takes into account the particular circumstances of consultant psychiatrists working in multi-disciplinary teams (see Annex A).

The development of mental status examination training for professionals at the Sussex Centre for Children and Young People

The aim of this project was to provide training to staff other than psychiatrists in risk assessments and to increase their confidence. At the end of the project both inpatient and outreach multi-disciplinary professional staff had the knowledge and the confidence to carry out the assessment of a life-threatening mental state and determine the action required. This enabled decisions to be made, for example about young people going on leave from the inpatient unit, without the junior doctor having to be called to undertake an assessment each time. Another outcome from the project has been that the ward round has been changed to a clinical team meeting, and whereas beforehand the consultant psychiatrist would take a lead in the discussion of cases and make the final decisions, now the chairing of the meeting rotates and decisions are made – and therefore owned – by the whole team.

Contact: Dr Tim Gillett, Sussex Partnership NHS Trust

Clinical responsibility

- 6.23 ‘Responsibility for the patient’ has in the past probably meant being the final arbiter of decision making in relation to that person’s healthcare. For most people nowadays, the provision of person-centred care will mean that the service user themselves is that final arbiter. If the service user is unable to take that responsibility for an appropriate reason, it can be taken by others according to legislation (Mental Health Act, Mental Capacity Act 2005, Children Act 2004), according to previously expressed choices, or by a senior practitioner taking the lead for decision making in complex or uncertain situations as discussed above.
- 6.24 Mental health care is more multi-agency and more complex than in the past, and practitioners in new and extended roles, as well as practitioners who have changed the way they work to meet needs more effectively, will all be potentially contributing to it.
- 6.25 It is therefore simpler to consider how responsibility operates at different levels of the system, as follows:
- individual team members have responsibility for the components of the care they provide (which need to be defined and clear)
 - all members of the team involved with the service user have responsibility for wider aspects of care, such as communication, respecting confidentiality etc
 - all members of the team have responsibility for contributing to the assessment of clinical risk and its appropriate management, with identified individuals responsible for undertaking specified tasks in the risk management plan and the care co-ordinator responsible for co-ordinating it
 - where CPA applies, the care co-ordinator has responsibility for ensuring that the patient is able to access all the required care (see ‘Care co-ordinator responsibilities’ below)
 - the team leader or manager is responsible for the smooth operation of the care pathway
 - the trust has responsibility for the provision of care to the quality standards agreed with its commissioners and required by its regulators.

- 6.26 Decisions will be made by individuals and service users, but good practice encourages team discussion of the more significant decisions, particularly where risk is involved, where more views on the issue will contribute to the safety and robustness of the ensuing plan. If one member of the team needs to take responsibility for the final decision, then who that is should be explicit within the team.
- 6.27 The degree to which decision making is distributed also needs to be appropriate to the circumstances. Clearly in an acute psychiatric emergency, or a risky situation occurring out of hours, the patient may not be able to take responsibility and there is a need for speed and clarity, so it is likely that one person will 'take charge', ensuring that the others involved are comfortable with the decisions and the actions required as far as practicable, but not spending time on discussion that could result in increased risk. In other situations, it may be that the speed of the decision is of the essence, but the decision itself is straightforward, in which case it is made by the person involved at the time.

Care co-ordinator responsibilities

- 6.28 *Refocusing the Care Programme Approach*³⁰ discusses the role of the care co-ordinator, but does not discuss this in terms of responsibilities. In more detailed guidance,³¹ 18 National Occupational Standards 'have been identified which reflect the task of care co-ordination', as set out below:

Comprehensive needs assessment

1. Assess individuals' mental health and related needs
2. Identify potential mental health needs and related issues
3. Identify the physical health needs of individuals with mental health needs
4. Contribute to the assessment of needs and the planning, evaluation and review of individualised programmes of care for individuals

Risk assessment and management

5. Develop risk management plans to support an individual's independence and daily living within their home
6. Assess individuals' needs and circumstances and evaluate the risk of abuse, failure to protect and harm to self and others
7. Assess the need for intervention and present assessments of individuals' needs and related risks

Crisis planning and management

8. Work with families, carers and individuals during times of crisis
9. Respond to crisis situations

³⁰ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

³¹ <http://cpaa.co.uk/cpa-core-competencies>

Assessing and responding to carers' needs

- 10. Work in collaboration with carers in the caring role
- 11. Assess the needs of carers and families of individuals with mental health needs
- 12. Develop, implement and review programmes of support for carers and families
- 13. Empower families, carers and others to support individuals with mental health needs

Care planning and review

- 14. Co-ordinate, monitor and review service responses to meet individuals' needs and circumstances
- 15. Plan and review the effectiveness of therapeutic interventions with individuals with mental health needs
- 16. Implement, monitor and evaluate therapeutic interventions within an overall care programme

Transfer of care and discharge

- 17. Plan and implement transfer of care and discharge with individuals who have a long-term condition and their carers
- 18. Work with others to facilitate the transfer of individuals between agencies or services

6.29 There is not an expectation that the full set of standards should be reflected in the role of an individual care co-ordinator; the individual's job description should state 'the scope of a practitioner's role and level of responsibility'.

Avon and Wiltshire Mental Health Partnership Trust: Art therapist working as care co-ordinator

A 0.5 whole time equivalent (wte) care co-ordinator post was combined with a 0.5wte art psychotherapist post to provide a full-time opportunity for the art therapist, who is fully integrated into the Community Mental Health Team, and undertakes both specialist and care co-ordination responsibilities. The team has gained a better understanding of the place of art therapy in patient care, the therapist is more accessible, and the therapist's different perspective has been successful in co-ordinating the care of several patients who had 'burnt out' the approaches of other team members.

From New Ways of Working for Allied Health Professionals³²

6.30 It is therefore for **employers** to determine the scope of responsibilities relating to care co-ordination and reflect this not only in job descriptions but in organisational policies and procedures. The employer could therefore determine, in line with the excerpts above, that care co-ordination does not bring with it the responsibility for delivering specific treatments or interventions, but does encompass responsibility for ensuring that those treatments and interventions are delivered, and taking reasonable action to rectify this when there is a problem. Hence, in this case, the care co-ordinator

³² www.newwaysofworking.org.uk/component/option,com_docman/task,cat_view/gid,196/Itemid,412/

takes responsibility for ensuring the delivery of the overall care plan, and the others involved take responsibility for the delivery of their components of the care according to their own professional and employee responsibilities.

Delegation versus distribution of responsibility

6.31 It is important to use these terms accurately, as whether work is delegated or distributed means that the accountabilities are different. Professional regulators have their own descriptions, which can add to the difficulty in distinguishing them.

6.32 For example, the GMC states that: “**Delegation** involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need.” (GMC (2006) *Good Medical Practice* Para.54 (see Annex A))

Suffolk Partnership Mental Health Trust: Pilot project to introduce specialist inpatient consultant psychiatrists in East Suffolk

The final report on this project noted: 'Historically there has been role confusion and unrealistic expectations of consultants. This was particularly the case in responsibility, leadership and accountability. All these factors, as well as increasing unrealistic expectations, led to increasing levels of stress.'

Traditional role

- Member of several teams
- Multiple areas of expertise
- Weekly supervision of a number of teams
- Delegation of work
- Increased burden of responsibility
- Professionals who meet infrequently
- Job unattractive to trainees
- Risk of 'burnout'
- Style – controlling

New role

- Member of one team only
- One focus of expertise
- Daily supervision of the team
- Distribution of work
- Collective responsibility
- True multi-disciplinary working
- Style – enabling

With more focused consultant psychiatrist time and leadership on the wards, it was possible to **distribute** responsibilities rather than delegating them, as team working was much improved.

- 6.33 The Nursing and Midwifery Council (www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=4184) advice states: ‘Where a nurse or midwife has authority to delegate tasks to another, they will retain responsibility and accountability for that delegation... Where another, such as an employer, has the authority to delegate an aspect of care, the employer becomes accountable for that delegation... The decision to delegate is either made by the nurse or midwife or the employer and it is the decision maker who is accountable for it.’ It goes on to say: ‘If the person to whom the task is delegated is in employment it is the employer’s responsibility to ensure that they have sufficient education and training to competently undertake the aspects of care which a nurse or midwife is expected to delegate to them.’
- 6.34 Joint guidance on delegation from registered practitioners to support workers³³ makes a distinction between **delegation** and **assignment**, and says: ‘In this context delegation is the process by which a registered practitioner can allocate work to a support worker who is deemed competent to undertake that task. This worker then carries the responsibility for that task. There is a distinction between delegation, and assignment. In the former case the support worker is responsible while the registered practitioner retains accountability. The latter case both the responsibility and accountability for an activity passes from one individual to the other.’ This is therefore analogous to distribution.
- 6.35 **Distribution** is when the responsibility for different components of the care is split between different members of the team. The members are acting in concert to provide the whole package; they are not necessarily doing this in line management relationships with one another, so they are all taking responsibility for the care they provide. One member of the team should have the overall responsibility for co-ordinating the care package or for making final decisions in relation to an individual’s care as appropriate.
- 6.36 An example of this might be where a package of care is being provided for a service user. Help to attend a training course may be provided by an STR worker, a psychologist may be providing cognitive behavioural therapy, a non-medical prescriber may be providing medication and a pharmacist may be providing information on the medication’s side effects to the patient and the family. One member of the team will have the additional responsibility of co-ordinating the care package.
- 6.37 In conclusion, therefore:
- When work is delegated from worker A to worker B, worker B takes responsibility for carrying out the work to the required standard, but the accountability rests with worker A.
 - When work is distributed by worker A to workers B and C, workers B and C are both responsible for carrying out the work to the required standard, and accountable to their employer/regulator for doing so. When support staff are assigned tasks the same applies.
 - When delegating, worker A must be mindful of the competences of worker B, but is entitled to assume that worker B has the competences defined by his/her qualifications or training. The employer has the responsibility for ensuring that the requisite training is provided; all workers are then personally responsible for utilising it appropriately.
 - A care co-ordinator working in a team where responsibility is distributed does not have responsibility for providing aspects of the care package that have been distributed, or assigned, to others. However, co-ordination does bring with it the additional responsibility to check that the

³³ www.rcn.org.uk/_data/assets/pdf_file/0006/78720/003093.pdf

care is being provided and, if it is not, to take appropriate action (checking with the practitioner concerned or raising the issue with the team manager as appropriate). If the care co-ordinator takes all reasonable steps to ensure that the plan is being delivered, and it is still not, it is the worker who is supposed to be delivering it who is accountable.

Referral and transfer of responsibility

- 6.38 When a service user is referred from one practitioner or team to another, concerns can arise about who is responsible for what. The GMC guidance offers a helpful definition: ‘Referral involves transferring some or all of the responsibility for the patient’s care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment that is outside your competence. You must be satisfied that any healthcare professional to whom you refer a patient is accountable to a statutory regulatory body or employed within a managed environment. If they are not, the transfer of care will be regarded as delegation, not referral. This means you remain responsible for the overall management of the patient, and accountable for your decision to delegate.’ (GMC (2006) *Good Medical Practice*)
- 6.39 It is therefore more helpful to think about the service user’s care along a continuum. If a GP refers a service user to the CMHT, the referral should make it clear what is being requested – an opinion as to what is the matter, advice on management that the primary care team will then carry out, or for the CMHT to provide the appropriate treatment. If there is then no ongoing involvement of the CMHT, the primary care team retains responsibility for the care plan; if the service user is offered treatment with the CMHT, there will be a sharing of responsibility that needs to be specified in the care plan – particularly in areas such as who is responsible for managing medication, and for monitoring physical health.

Steve is a young man who suffers from schizophrenia and abuses drugs, and he has a history of violence. His care is managed in the community with input from several members of the multi-disciplinary team and good liaison with primary care. When Steve moves to another part of the country, a referral is made to his new local CMHT, who say they need to assess him again and this will take four weeks. During this time Steve becomes very psychotic and commits a violent assault.

Q: Who is responsible?

A: Any investigation would look at the practice of both teams to determine:

- whether the referring team had done everything they could to assure safety – referring as soon as they could, providing adequate information, contacting the team directly if there were risk concerns, ensuring an adequate supply of medication during the move, keeping in touch with the patient by phone/text/email, keeping in touch with carers, alerting the new GP
- whether the receiving team had assessed the information they received and acted appropriately – making a reasonable judgement of the degree of risk, seeking clarification if necessary, making arrangements to see Steve that were timely and acceptable to him.

- 6.40 It is particularly important to be clear about responsibilities during referral processes; service users and carers will be particularly vulnerable at this time if they do not know who is supposed to be providing what, and who to contact if there is a problem. Organisations and their teams therefore need to have clear access and transfer protocols agreed with all partners, but as well as those, flexibility is key to ensuring that there are no gaps, as service users' individual circumstances will differ.
- 6.41 The management of risk is always multifactorial, and effective communication is key. During a referral process the following should be considered:
- Has the referrer made an adequate assessment of the level of risk, based on the information available, and communicated this to the mental health team?
 - Has the mental health team take into account the risk information in the referral, for example seeing the service user within a timeframe commensurate with the level of risk identified?
 - Was the service user given information, by the primary care practitioner at the point of referral and by the mental health team when processing the referral, to allow them to access help more rapidly if the mental condition deteriorated?
 - Was there sufficient information available to allow a concerned carer to access help or advice if the situation deteriorated?
 - Are the processes robust, for example for ensuring that referrals are sent swiftly and accurately, and received and managed in an efficient manner?
- 6.42 A particular type of transfer occurs at the **transition** points between services, for example between children's and adolescent and adult services, or adult and older adult services. The same general principles apply, and often the need for the service user to move to the other service can be predicted some time in advance, which provides the opportunity for a period of joint working to optimise the success of the transition. This should be possible whether or not the two services are within the same organisation. It is important to be clear which service is responsible for what at all points during the process. Providers have transition protocols which set out the expectations; as ever, in addition to following the protocols, sensitivity to individual circumstances is needed.

7 Responsibilities in practice

Personal responsibility

- 7.1 Everyone providing or in receipt of mental health care will have individual responsibilities. Formal statements will never be able to capture them completely, because of the need to take responsibility for doing something when confronted with a situation that requires it. Responsibility should go hand in hand with initiative, not be a dead hand upon it.³⁴
- 7.2 The Handbook to the NHS Constitution³⁵ describes the responsibilities of the NHS and its staff and those of patients. Nine patient responsibilities are outlined:
- taking (some) responsibility for contributing to self/family's good health and wellbeing
 - registering with a GP
 - treating NHS staff and other patients with respect
 - providing accurate information
 - keeping appointments or cancelling in good time
 - following the agreed treatment plan
 - participating in important public health programmes
 - ensuring that family are aware of wishes regarding organ donation
 - giving feedback about treatment and care.

Taking personal responsibility³⁶

A project at Leeds Partnerships Foundation Trust aimed to move away from a perceived blame culture and develop a supportive approach to changing behaviour and practice. The project encouraged staff to take more personal responsibility for their actions and the impact on others, and to feel able to challenge where appropriate. They were assured of being able to voice concerns in confidence and without over-reaction. Staff sickness was reduced by 20%, the number of complaints relating to staff attitudes fell significantly, and there was a 90% reduction in disciplinary cases.

³⁴ Fay D and Frese M (2000) *Self-starting behaviour at Work: Towards a theory of personal initiative*. In Heckhausen J (ed) *Motivational Psychology of Human Development: Developing motivation and motivating development*. New York, NY: Elsevier Science

³⁵ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093421

³⁶ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5918705

7.3 In taking individual responsibility, the practitioner should:

- recognise and work within the limits of their competence
- record interventions, advice received and from whom, decisions and rationale
- recognise that telling someone else about a problem does not absolve the practitioner of responsibility for helping to solve it
- ensure that the service user and carer are as clear as possible about what has been agreed
- ensure that, in accordance with information-sharing protocols, all parties are as well informed as possible where decisions are made against a service user's or carer's wishes, and of the reasons why.

Decision making

7.4 Effective decision making requires that the team is clear about the type of decisions to be made and who should make them. Four types of decision making can be delineated (after Øvretveit, 1993³⁷), and these are briefly described below with guidance as to who might be responsible for them.

- **Decisions about work with an individual user within the user–staff member relationship.** This will include arrangements made with the team member and the user for how they will manage their work, such as when they will meet and where. It also includes profession-specific decisions that do not need wider consultation, such as which profession-specific assessment to use (for example for assessing activities of daily living skills, or vocational preferences), or which medication. It is good practice to be constantly ready to seek advice and support that will inform and improve decision making.
- **Care co-ordination decisions concerning an individual user.** These decisions will be taken by a care co-ordinator in partnership with the user themselves, carers and others involved. It is this group of people that constitutes the team for the purposes of meeting the needs of the client. It is therefore in this domain that most team communication needs to take place. Care co-ordination decisions include, for example, who should be working together and how, what the objectives of different inputs to care are, whether a new or different approach should be used, and whether other resources can be brought to bear to improve the situation.

These decisions should be very visible and subject to regular review by the team as a whole, who should feel able to challenge the decisions and suggest alternatives. Indeed, the team as a whole and the user themselves are a resource for thinking creatively about alternatives. Only in rare cases will there be a prescribed team policy that will tell the practitioner everything they need to know. This is very different to the model where one practitioner (often a doctor) decided what was best and who should do it. It emphasises the primacy of clinical person-centred considerations.

- **Policy or management decisions** about how the team serves all users, and how care co-ordination will be undertaken within the team. In order to promote sound policy and effective implementation, it will be important that all team members are involved in such decisions. The CCTA is an NWW tool that helps the team, in collaboration with its service users and carers, to define clearly how it can best meet the needs of its clientele within the resources available.

³⁷ Øvretveit J (1993) *Co-ordinating community care: Multi-disciplinary teams and care management*. Buckingham, PA: Open University Press

- **Planning decisions**, for example about the team's objectives, the assessed needs of the client group or substantial changes in operational policy. These decisions will extend to involve people outside of the team, but clearly should include team members in order to ensure that the decisions are informed by practical experience and to ensure appropriate ownership of new ideas and effective implementation.

Prescribing

- 7.5 Appropriately qualified and trained practitioners may give recommendations to another about medication, or general or specific advice, as well as prescribing medication directly to the service user. The GMC guidance is useful for all prescribers³⁸ and says: 'If you are the doctor signing and issuing the prescription you bear responsibility for that treatment; it is therefore important that, as the prescriber, you understand the patient's condition as well as the treatment prescribed and can recognise any adverse side effects of the medicine should they occur.'
- 7.6 With regard to who prescribes, it says: 'There should be full consultation and agreement between general practitioners and hospital doctors about the indications and need for particular therapies. The decision about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests rather than on the healthcare professional's convenience or the cost of the medicine.' See also the Nursing and Midwifery Council (NMC) Standards of Proficiency for Nurse and Midwife Prescribers.³⁹

Using clinical guidelines

- 7.7 Guidelines, such as those from NICE, inform professional practice but do not dictate it. Practitioners have a responsibility to understand the evidence available, and if they depart from the guidance, they should be able to justify their reasons for doing so.

Providing advice

- 7.8 Providing advice about a person the practitioner has not seen occurs frequently when primary care clinicians ask for advice from specialists, or occasionally the reverse, and within mental health teams. The following principles should be adhered to:
- Agree who will record the advice; this may often be the person who has requested it.
 - The person giving advice should ask sufficient information about the case to be comfortable in providing it. There needs to be proportionality, so the record might say 'based on the information I have received'.
 - Records should be secure and accessible; however, they do not need to be made in several places. For example, the GP can make a record and the secondary mental health service should then be able to access it if necessary.
 - Best practice would indicate that for telephone contact the advice should subsequently be provided in writing so that it can be incorporated into primary care or other records. This can be done by email.

³⁸ www.gmc-uk.org/guidance/current/library/prescriptions_faqs.asp

³⁹ www.nmplearningnw.org/precourses/Standards_of_Proficiency_N_MW_P.pdf

- Advice can be given about principles or evidence-based practice that will not need to be recorded in a particular set of notes.

Plymouth Primary Care link working; sharing care and responsibility

The function of Plymouth's primary care liaison teams has been redesigned to include all community mental health professionals, who provide advice and link with specific clinics in general practice to carry out brief assessment and signposting under primary care, providing reviews and sharing care with GPs for those with less complex needs and at a lower level of risk.

Records are entered directly into GP systems, and discussions about care development take place in liaison with patients, carers and primary care team members.

- 7.9 Researchers or acknowledged experts in their field may be contacted by service users or carers asking for advice because their work has been profiled in the media, or found on the internet. Since the expert will still be bound by professional responsibilities, they will usually confine replies to providing general information about the particular skill, research finding, therapy, medication etc, but refer the enquirer back to their own local service for proper evaluation of the individual case.

The primary/secondary care interface

- 7.10 *New Ways of Working for Primary Care Mental Health: a briefing document*⁴⁰ gives detailed guidance for effective working across the crucial primary/secondary care interface. Responsibility issues need to be clear in respect of the following:

- The division of responsibilities across interfaces, to avoid the potential for service users and carers to 'fall through the gap'.
- Documenting in and storing one NHS record, with appropriate access when necessary, to avoid needless duplication where services are co-located.
- With regard to mental health service users with long-term conditions, not only who is responsible for what, but how long the arrangement is for and how it gets reviewed. This is particularly important when medication is being prescribed on a long-term basis. The prescriber needs knowledge of all the prescribed medications, not just psychotropics, in order to anticipate interactions or manage side effects.
- Joint working within the CPA and other care navigator functions (such as the Common Assessment Framework) should ensure proportionate engagement of all involved in the care of individuals with complex needs.

⁴⁰ www.newwaysofworking.org.uk/component/option,com_docman/task,cat_view/gid,213/Itemid,412/

Record keeping

- 7.11 Keeping records is a responsibility in itself, and the record is also evidence of the discharge of other responsibilities. It is appropriate for a practitioner to delegate the task of recording (for example a consultant psychiatrist asking the trainee doctor to do it) or for a multi-disciplinary assessment or decision to be recorded by only one person – however, the record should be sure to note the others who were involved.
- 7.12 Electronic care records will automatically record who makes each entry and when. NMC guidance on record keeping⁴¹ says that if a non-qualified member of staff or a student to whom a task has been delegated has not had their record-keeping skills assessed, the records they make should be countersigned, and it is the responsibility of the supervisor to decide when this is required. However, such systems do not mean that the supervisee abrogates responsibility for the accuracy of the record. Role-based access to records is designed to ensure that staff have the level of access to individual records, or to parts of the system, that they need to carry out their job, while ensuring confidentiality for service users.
- 7.13 Different professions keep different sorts of records, and this will continue to be the case. It is possible for the organisation to have standards for record keeping that apply to all, while the content of the records will vary. Records will, however, need to be understandable to all the members of the team. The aim of record keeping is to ensure that the right people have the right information to provide the best care for the service user.
- 7.14 Electronic care records require much higher standards of computer literacy among all staff than have previously been needed. This brings more responsibilities for employers to ensure that the workforce has the necessary skills, but also for practitioners to ensure that they can match the level of skills required in the job description and person specification for a particular job.

Oxfordshire and Buckinghamshire Mental Health Foundation Trust: using technology to enhance care

Cotswold House Marlborough is a new eating disorders unit and the first Trust inpatient facility with a primary electronic health record. The team secretary has been trained to assist staff with health record queries and runs training in basic computer skills. Staff also:

- use email to ensure that clinical decisions can be made swiftly, include the whole care team and are recorded
- use multi-disciplinary assessments and templates for reports to which staff contribute electronically, so patients only tell their story once and further detail can be added when they are settled
- encourage patients to access the internet themselves using the ward wireless network, or alongside a support worker using a Trust computer
- use teleconferencing to enable carers and teams working a distance away to join CPA reviews, and are developing the use of a webcam for distance family therapy
- encourage service users to use the Trust's Twitter and Facebook.

⁴¹ www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=6269

Information sharing and confidentiality

7.15 Practitioners may have anxieties about their responsibilities for **sharing information**. Services, both statutory and non-statutory, have policies about confidentiality and protocols about information sharing with partner organisations and third parties. There are circumstances in which it is acceptable to breach patient confidentiality in order to manage risk appropriately. More detailed guidance is available from *Confidentiality: NHS Code of Practice*,⁴² information on carers and confidentiality produced by the Partners in Care campaign,⁴³ *Good Psychiatric Practice: Confidentiality and information sharing*⁴⁴ and the NMC guidance on confidentiality.⁴⁵ The GMC publishes confidentiality guidance for doctors that addresses issues concerning both disclosures in the public interest to protect the patient and/or others from serious harm, and listening to carers with concerns about a patient.⁴⁶

Raising concerns and whistleblowing

7.16 Service users and carers who have concerns or are lacking essential information now have more avenues to pursue to get them addressed. They can speak to staff directly, or go to their local Patient Advice and Liaison Service (PALS), or make a formal complaint, which should be addressed to the chief executive of the provider trust. Local resolution is key to getting the best outcome from the complaints process. Patient Opinion is a website where patients and carers post their views about their care and local services, and it is going to be extended to mental health.⁴⁷

7.17 Staff have a responsibility to raise concerns, which may be about the conduct, performance or health of a colleague, or about policies, systems or procedures which they think may put service users or carers at risk.⁴⁸

7.18 Trusts are required to have a whistleblowing policy, which should be consulted by staff who have concerns about practice, and regulators also provide guidance, for example the NMC Guidance 'Environment of care'.⁴⁹ NHS Employers has support for employers developing policies on its website, and is also developing links to case studies.⁵⁰ The Public Interest Disclosure Act 1998⁵¹ gives protection to employees by stating that trusts ensure as a minimum:

- the designation of a senior manager or non-executive director with specific responsibility for addressing concerns raised in confidence which need to be handled outside the usual line management chain
- guidance to help staff who have concerns about malpractice to do so reasonably and responsibly with the right people
- a clear commitment that staff concerns will be taken seriously, and investigated

⁴² www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253

⁴³ www.carers.org/data/files/carersandconfidentiality-13.pdf

⁴⁴ www.rcpsych.ac.uk/files/pdfversion/ct133.pdf

⁴⁵ www.nmc-uk.org/aArticle.aspx?ArticleID=3614

⁴⁶ <https://gmc.e-consultation.net/econsult/uploaddocs/Consult50/Confidentiality%20-%20a%20draft%20for%20consultation.pdf>

⁴⁷ www.patientopinion.org.uk/blog/

⁴⁸ www.gmc-uk.org/guidance/current/library/raising_concerns.asp

⁴⁹ www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3987

⁵⁰ www.nhsemployers.org/EmploymentPolicyAndPractice/Pages/Whistleblowing.aspx

⁵¹ www.dh.gov.uk/en/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/DH_4004385

- an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

7.19 Employers decide how to investigate and manage concerns that are raised. They may need to involve the appropriate regulator, or the National Clinical Assessment Service⁵² where there is concern about the performance of a doctor or pharmacist.

⁵² www.ncas.npsa.nhs.uk/

8 Responsibilities in law

- 8.1 This section provides a brief overview of the key legislative background, but is not a substitute for reading the statutes and specific guidance, or for obtaining up-to-date legal advice in individual circumstances.

Mental Health Act 2007

- 8.2 The Mental Health Act 2007 amended the Mental Health Act 1983 to replace the role of the Responsible Medical Officer (RMO) with that of the Approved Clinician (AC). An individual detained patient now has an AC who acts as the Responsible Clinician (RC). The RC is defined as the AC with overall responsibility for the patient's case. This person may be a doctor, nurse, psychologist, social worker or occupational therapist. This is an example of an NWW extended role – one that has traditionally been filled by doctors alone but which is now extended to other professions.
- 8.3 If the RC is a non-doctor and not a prescriber and medication is needed, an AC who is a doctor would have responsibility for this part of the overall plan. In instances where the patient has more than one AC involved in their care, however, only one of them can take the RC role at any one time.
- 8.4 The Approved Social Worker role has become that of Approved Mental Health Professional, and eligibility for the role is extended to nurses, occupational therapists and psychologists as well as social workers.
- 8.5 There are also changes in the Code of Practice which are relevant to discussion of responsibilities. Reviews in seclusion can be carried out by a suitably qualified professional, so this no longer has to be a doctor (NB: although the term 'medical treatment' is retained in the Act, its definition includes all types of care delivered by a multi-disciplinary team).
- 8.6 Organisations are able to make their own arrangements for covering RC responsibilities out of hours or when the RC is away. Practitioners need to be aware that local protocols may therefore differ between trusts.

Mental Capacity Act 2005

- 8.7 The Mental Capacity Act (MCA) applies 'to everyone who works in health and social care and is involved in the care, treatment or support of people...who are unable to make all or some decisions for themselves'.⁵³ The test of what is in an individual patient's best interests is central to all decision making involving patients who lack capacity.

⁵³ www.dca.gov.uk/legal-policy/mental-capacity/mibooklets/booklet03.pdf

- 8.8 The assessor of an ‘individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made’; this means that different health and social care workers will be involved in different capacity decisions at different times.⁵⁴ Capacity is assessed in relation to the particular decision which needs to be made, and all practicable steps should be taken to maximise capacity.
- 8.9 The Mental Capacity Act Deprivation of Liberty safeguards (DOLS)⁵⁵ (formerly known as the Bournemouth safeguards) were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007. The MCA DOLS protect people who cannot make decisions about their care or treatment, who need to be cared for in a restrictive way, for example some people with dementia, another severe mental health problem or a learning disability. Six assessments are required to be carried out under DOLS: age assessment, mental health assessment, mental capacity assessment, best interests assessment, eligibility assessment and no refusals assessment. Best interests assessors and mental health assessors have to undertake specific training to discharge their responsibilities. These assessors will be subject to a role-specific regulatory framework. The mental health assessor needs to be a medical practitioner; the best interests assessor may be a social worker, nurse, occupational therapist or chartered psychologist.⁵⁶
- 8.10 In 2007, the new role of Independent Mental Capacity Advocate (IMCA) came into being. IMCAs ‘represent and support people without capacity, and mainly without family and friends to support them in important decisions’. Health and social care workers have a legal duty to refer eligible people to the Independent Mental Capacity Advocacy Service.⁵⁷ IMCAs will have additional responsibilities under the MCA DOLS.

Children Act 2004

- 8.11 The Children Act 2004 outlines new statutory duties and clarifies accountabilities for children’s services. It is based on the document *Every Child Matters: Change for Children*⁵⁸ which aims to build services around the needs of children and young people in ways that maximise opportunity and minimise risk. It requires services to be more integrated to achieve this, and states, ‘delivering more integrated services requires new ways of working and significant culture change for staff used to working within narrower professional and service-based boundaries’.
- 8.12 Section 11 of the Children Act 2004 places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children. This includes mental health providers. The children concerned do not have to be referred to the service; they may be children of, or cared for by, service users or they may be young carers. In discharging their responsibilities under the Act, mental health trusts and local authorities will make explicit the responsibilities of their staff with respect to safeguarding.⁵⁹

⁵⁴ Department for Constitutional Affairs (2007) Mental Capacity Act 2005 – Code of Practice

⁵⁵ www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm

⁵⁶ www.opsi.gov.uk/si/si2008/pdf/uksi_20081858_en.pdf

⁵⁷ The First Annual Report of the Independent Mental Capacity Advocacy Service; DoH 2008

⁵⁸ www.dcsf.gov.uk/everychildmatters/about/background/background

⁵⁹ www.gmc-uk.org/guidance/ethical_guidance/children_guidance/index.asp

Human Rights Act 1998

8.13 The Human Rights Act came into effect in the UK in October 2000. The rights contained in the European Convention on Human Rights, drafted by the Council of Europe, after World War II, are enshrined in the Act. Of the 16 articles, the ones most relevant to issues of responsibility and accountability in mental health practice are likely to be:

- Article 2: Right to life
- Article 3: Prohibition of torture (includes inhuman or degrading treatment)
- Article 5: Right to liberty and security
- Article 8: Right to respect for private and family life
- Article 14: Prohibition of discrimination.

Anti-discrimination legislation

8.14 The **Race Relations Act 1976**, as amended in 2000, places a statutory duty on NHS organisations (strategic health authorities, PCTs, NHS trusts, NHS foundation trusts and special health authorities) to promote race equality. This duty covers all aspects of an organisation's activities, including policy and service delivery, as well as employment practices. In particular, there is a statutory requirement on NHS organisations to review and consult on their race equality schemes.

8.15 The **Sex Discrimination Act 1975** prohibits sex discrimination against individuals in employment, education, and the provision of goods, facilities and services. The **Gender Equality Duty**, which came into force on 6 April 2007, is an amendment to the Act and places a legal obligation on public authorities to promote equality of opportunity between men and women, and actively demonstrate that men and women are treated equally and fairly in the exercise of public functions. All public organisations must publish a gender equality scheme.

8.16 Since December 2006 there has been a statutory duty on public bodies to promote equality of opportunity for disabled people (the **Disability Equality Duty**). Disabled people are defined as those who have, or have had, a physical or mental impairment that has a substantial effect on their ability to carry out day-to-day activities and that has lasted, or is likely to last, at least 12 months.

8.17 The **Equality Bill**⁶⁰ is intended to replace the three existing separate duties covering race, gender and disability with a single integrated public sector duty, which will also be extended to include sexual orientation, religion or belief, age and gender reassignment. The Government will consult on which public bodies will be subject to the requirements, and what information they must publish. This suggests implementation around 2010/11 at the earliest.

⁶⁰ www.equalities.gov.uk/equality_bill.aspx

Corporate Manslaughter and Corporate Homicide Act 2007

8.18 The Corporate Manslaughter (England, Wales and Northern Ireland) and Corporate Homicide (Scotland) Act introduces an offence, for which companies and other organisations can be prosecuted, where there has been a gross failure, throughout the organisation, in the management of health and safety with fatal consequences. It is the organisation which is prosecuted, not the individual, and if guilty it faces an unlimited fine. The responsibilities of directors and individuals under health and safety law and the criminal law remain unchanged. The Act does not yet apply to deaths in custody or detention.

9 Responsibilities of employers

- 9.1 It is important for practitioners to be aware that employing authorities have statutory obligations and a direct duty of care towards users, carers, visitors and their own employees. They need to ensure that those they employ are suitably qualified, competent and supported to carry out their roles. Employers also have a duty to provide a safe system of care for both users and employees. They must provide proper facilities, equipment and training and ensure that staff are able to exercise their professional responsibilities. They are also responsible for the development and monitoring of realistic operational policies. If the employer supports the extension of professional roles, for example by training non-medical prescribers, they must support staff to exercise these extended roles once trained.
- 9.2 The organisation is responsible for creating an agreed accountability framework within which its staff work. This should always be aligned with professional responsibilities.
- 9.3 All organisations providing care for those with mental health problems and their carers are likely to have as their focus a person-centred approach to the delivery of safe, effective, holistic care across the health and social care continuum.
- 9.4 Organisations may use *The Ten Essential Shared Capabilities*⁶¹ and the *Capabilities for Inclusive Practice* to reinforce their commitment to their core values.⁶²
- 9.5 The integrated governance structure should be clear to all staff, as should their responsibilities in respect of governance, for example cascading information, reading and acting according to trust policy, and understanding their responsibility for reporting incidents or concerns.
- 9.6 Effective health and social care governance within a trust ensures that:
- the people who use the trust's services and their carers are fully informed and involved in all decisions relating to their care, and that their health and social wellbeing is actively promoted
 - the people responsible for services and care constantly seek to modernise and develop, and that they are supported by evidence-based procedures and policies
 - there is a strong commitment to the delivery of high-quality services, underpinned by robust structures and pathways
 - it consistently embeds within the organisation the learning outcomes from untoward events, and that risks are understood and managed.
- 9.7 There are new and emergent roles that are not currently regulated. They are also not associated with any of the 'traditional' mental health and social care professions, so they may be called 'non-professionally regulated' or 'non-professionally affiliated'. For these non-professionally affiliated practitioners at present, formal accountability will be only to the employer, although there are discussions with the regulatory bodies regarding a regulatory framework and code of conduct.

⁶¹ www.socialinclusion.org.uk/publications/10ESC.pdf

⁶² www.socialinclusion.org.uk/publications/DHcapabilities_05.pdf

Sometimes colleagues are anxious about this, but usually their competencies, training requirements and the tasks they are expected to perform are well set out in job descriptions, person specifications, competency frameworks, training schedules and terms and conditions, and this should provide assurance. Organisations may also develop codes of conduct in addition to terms and conditions for these workers.

- 9.8 Employers are vicariously liable for the acts of their employees when acting in the normal course of their employment. However, this may not protect the individual practitioner from personal litigation (see below).

Indemnity and liability

- 9.9 NHS bodies are legally liable for the negligent acts and omissions of their employees (the principle of vicarious liability), and should have arrangements for meeting this liability.

- 9.10 NHS indemnity applies where:

- the negligent healthcare professional was working under a contract of employment (as opposed to a contract for services) and the negligence occurred in the course of that employment, or
- the negligent healthcare professional, although not working under a contract of employment, was contracted to the NHS.

- 9.11 Clinical negligence is defined as ‘a breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgements made by members of those professions acting in their professional capacity in the course of their employment, and which are admitted as negligent by the employer or are determined as such through the legal process’.⁶³

- 9.12 The GMC requires doctors to take out adequate cover for anything not covered by NHS indemnity ‘in your patient’s interests as well as your own’,⁶⁴ and there could be grounds for taking action against a doctor if a service user is seriously disadvantaged as a result of the doctor not having adequate cover.

- 9.13 Defence organisations (for example the Medical Protection Society,⁶⁵ the Medical Defence Union) and trade unions (for example Unison,⁶⁶ Unite) recommend that professionals take out insurance or personal indemnity cover in addition, to cover the occasions where the employer’s cover may not protect the employee.

- 9.14 If a practitioner is sued, the legal test of responsibility for the standard of care is defined by the Bolam test, as later modified by the case of Bolitho (see Annex B).

⁶³ www.nhs.uk/NR/rdonlyres/1CFE5864-05C3-4770-982C-7003294B8161/0/NHSIndemnity.rtf

⁶⁴ www.gmc-uk.org/guidance/good_medical_practice/index.asp

⁶⁵ www.medicalprotection.org/

⁶⁶ www.unison.org.uk/healthcare/pages_view.asp?did=1183

10 Professional accountabilities

- 10.1 The content of this document does not contradict any of the extant guidance from professional organisations and regulators. Further details are given in the appendices and on each website.
- 10.2 However, language can differ and for effective teamworking it is important to understand the professional context in which colleagues from different professions operate. Working out who the professional regulators are can be difficult for other staff and service users and carers: the table below distinguishes regulators from professional bodies (colleges etc).

Profession	Regulatory body	Professional body
Arts therapists	Health Professions Council (HPC)	British Association of Art Therapists British Association of Dramatherapists Association of Professional Music Therapists
Dieticians	HPC	British Dietetic Association
General practitioners	GMC	Royal College of General Practitioners
Non-professionally affiliated workers	None	No professional body. Guidance on responsibility issues has been issued by other professional bodies ^{67,68}
Nurses	Nursing and Midwifery Council (NMC)	Royal College of Nursing also acts as a trade union The Mental Health Nurses Association is a professional association and trade union for mental health nurses in the health sector of Unite
Occupational therapists	HPC	British Association/College of Occupational Therapists
Pharmacists	Royal Pharmaceutical Society of Great Britain (RPSGB)	RPSGB*
Physiotherapists	HPC	Chartered Society of Physiotherapy
Psychiatrists	General Medical Council (GMC)	Royal College of Psychiatrists

⁶⁷ www.rcn.org.uk/__data/assets/pdf_file/0004/198049/HCA_booklet.pdf

⁶⁸ www.rcn.org.uk/__data/assets/pdf_file/0006/78720/003093.pdf

Profession	Regulatory body	Professional body
Psychologists	From July 2009, the statutory regulator for the BTS is HPC from July 2009	British Psychological Society (BPS)
Psychotherapists	Voluntary regulation United Kingdom Council for Psychotherapy (UKCP) Association of Child Psychotherapists (ACP) British Association for Counselling and Psychotherapy (BACP) British Association for Behavioural and Cognitive Psychotherapies (BABCP) British Psychoanalytic Council (BPC)	UKCP – Humanistic and Integrative Psychotherapy (UKCP-HIP) UKCP – Council for Psychoanalysis and Jungian Analysis (UKCP-CPJA) UKCP – Cognitive Psychotherapies (UKCP-CP) UKCP – Hypnotherapy (UKCP-HP) UKCP – Constructivist (UKCP-C) UKCP – Family, Systemic and Relationship Psychotherapies (UKCP-FSRP) UKCP – Psychotherapeutic Counselling (UKCP-PC) ACP BACP BABCP BPC
Social workers	General Social Care Council	Largest is British Association of Social Workers
Speech and language therapists	HPC	Royal College of Speech and Language Therapists

10.3 Healthcare staff may also belong to one of a number of trade unions, or none. Unison is the largest health service union; others include Amicus/Unite, GMB, BMA and Managers in Partnership. Trade unions produce a variety of guidance; see their individual websites for details.

11 Definitions

11.1 Relevant definitions, which are not always used consistently across professions or organisations, are elaborated below for reference.

Competence and capability⁶⁹

11.2 When work is being either distributed or delegated, the individual who carries it out needs to be competent to do so. **Competence** is an individual's ability to effectively apply knowledge, understanding, skills and values within a designated scope of practice. It is evidenced in practice by the effective performance of the specific role and its related responsibilities. Competence also involves individuals in critical reflection about, and modification of, their practice. Competence is a general term and rests on the consensus view of what forms good practice.

11.3 **Competencies** are statements about what needs to be carried out within the workplace and therefore form part of how practice can be described. Underpinning these competencies is all the knowledge, understanding and skills that individuals have, together with their professional values and beliefs. If individuals possess qualifications, for example professional qualifications, NVQs etc, then colleagues, service users and carers have a right to assume that the person has the competencies required to gain that qualification, and has kept their knowledge and skills updated. The individual thus has a responsibility to do this. However, in roles where individuals do carry out delegated tasks, for example healthcare assistant and assistant practitioner roles, the possession of the training and the qualification indicates competence but does not confer the right to undertake any particular task; the decisions as to what to do remain with the supervising registered practitioner and are taken with consideration to the needs of the service user and the organisation.⁷⁰

11.4 **Capability** relates to the individual's full range of potential and may go beyond their current scope of practice. It can be considered as potential competence. An individual's **performance** is a measure of their competence in action.

Supervision, coaching and mentoring

11.5 **Supervision** is integral to the provision and governance of a quality service, to the training and lifelong learning of its staff, and therefore to the experience of service users and carers. Different professions have used varying descriptions of the arrangements for supervision of clinical work for both trained and trainee staff, meaning that colleagues in a team may not always be clear what is intended or required. The section below describes the main types of arrangement.

⁶⁹ www.csp.org.uk/uploads/documents/CC_pack_published_version_June_05.pdf

⁷⁰ www.rcn.org.uk/_data/assets/pdf_file/0004/198049/HCA_booklet.pdf

- 11.6 Practice (trainee) supervision operates in the context of a formal relationship between a more senior and a more junior team member who has yet to achieve the status of an independent practitioner accountable for their own clinical decision making.⁷¹ In the relationship, therefore, both parties will have responsibilities and accountabilities; the trainee is still responsible for practising within the recognised scope of practice and being able to demonstrate that. In psychiatry, when applied to the relationship between a more senior and less senior doctor, this is referred to as clinical supervision.
- 11.7 The senior member of staff may or may not be in a line management relationship to the trainee. Equally, line managers may be responsible for ensuring that practice supervision is provided but not provide it themselves. If the supervision relates to the practice of a particular skill or demonstration of a particular competency, the practice supervisor may not necessarily be from the same profession.
- 11.8 Under the Agenda for Change agreement, nursing and allied health professionals are required to develop and sustain local programmes of preceptorship. It was introduced for newly qualified professional staff joining the NHS at Band 5 and provides accelerated progression through the first two points in six-monthly steps, provided that the outcomes from practice supervision are satisfactory.
- 11.9 **Educational supervision.** Psychiatry (and the rest of medicine, as determined by the Postgraduate Medical Education and Training Board) operates a system whereby, following training and selection for the role, the consultant psychiatrist acts as an educational supervisor for the doctor in training. Educational supervision has to be provided for each trainee for at least one hour a week. The content of educational supervision may include clinical material, but this hour should not be used for the routine supervision of clinical work. Other aspects of educational supervision include development of teaching and research skills, management and administration, and pastoral care. The session ‘belongs’ to the trainee who should take the lead in determining the content, in line with the aims and objectives set at the beginning of the training attachment.
- 11.10 **Clinical supervision**, which may be called peer supervision when provided between trained staff of equivalent seniority, is about discussing the practitioner’s approach to the care of patients. This form of supervision is about support and advice given within and across disciplines by trained, competent and qualified practitioners (and trainees in psychiatry, see above). It is an important reason for operating in a team. Within the team, practitioners should be able to seek support for their clinical work from whoever they judge to be most suitable, and in the most appropriate manner – lack of formal accountability does not render the support and advice given in clinical review meetings, for example, any less valuable.
- 11.11 Conducted on an individual basis, regardless of seniority, clinical supervision helps to continuously develop the capabilities of the practitioner and may also be required to help practitioners recognise where they may be exceeding their competence. It may be the only way for consultant-level practitioners to discuss difficult clinical problems and elicit the views of others in finding a way to manage them. Having received it, as with all advice, it is the practitioner working with the service user who is responsible for deciding what action to take and for recording it.

⁷¹ Beinart, H (2004) Models of supervision and the supervisory relationship and their evidence base. In I Fleming and L Steen (eds) *Supervision and Clinical Psychology*. Hove: Brunner-Routledge

- 11.12 **Caseload** or **management supervision** is undertaken by team managers, who have a responsibility for ensuring that the workload capacity of the team is optimised and maintained, so that service users and carers move through the care pathway in a timely and efficient manner. There are various tools available to support this activity, which comprises the team manager reviewing the caseload of an individual practitioner on a regular basis, to promote consistency in applying thresholds for receiving interventions and care across the team.
- 11.13 If there are unexpected problems with capacity management, for example staff sickness or a sudden influx of service users into the system, it is the team manager's role, in collaboration with the team, to make the necessary adjustments to team working practices and caseloads in order to cope. NWW can be used to optimise the capacity of the team, by ensuring that all the members are doing the work most appropriate to their skills and experience and allowing for the efficient running of the system.
- 11.14 In a team using a NWW approach, the most experienced and skilled members will be working with the service users with the most complex needs. They will not be directly involved in the care of other service users with more straightforward needs. Instead, they will be available to be consulted by other team members, and provide advice and support relating to the care of these patients. In this case the senior practitioner is responsible for the quality of the advice, but the recipient is responsible for decisions about taking it and providing the ongoing care. This is not technically a supervisory relationship.
- 11.15 **Mentoring** also differs from supervision; it is a relationship that enables one person (the mentee) to get support and advice and develop ideas with another (the mentor). The mentor and mentee need not be in the same profession, the same type of work or the same organisation, but the experience and skills of the mentor will be relevant to the mentee's job in some way. The topics discussed will often be broader and more strategic, encompassing the wider working relationships of the mentee, work-life balance, dealing with conflict, etc. Some staff have mentors through defined schemes, for example to support black and minority ethnic staff, and others seek mentors informally. Meetings will generally be less frequent than those for peer supervision, and the need for the mentoring relationship may be time limited.
- 11.16 **Coaching** tends to be a tool used by more senior practitioners and managers. A coach will use focused conversation and perhaps psychometric tests. Coaching is usually done in longish (an hour and a half to two hours) sessions over a period of some months. It is used to improve effectiveness, enhance management and leadership skills, balance personal and organisational goals, improve interpersonal skills and provide a focus for personal development.

Leadership and management

- 11.17 In clinical teams, there is often a distinction between clinical leadership and management roles, although at other levels of the organisation the same people may be deemed to have both leadership and management responsibilities. There is currently a great deal of focus on the importance of leadership in healthcare, and this can undermine the value and contribution of management. **Leadership** is seen to be concerned with people and with the future, while **management** is focused on efficiency and the present. If leadership is about developing vision and strategy, and management about planning, organising, budgeting and troubleshooting, then it is swiftly apparent that in a constantly changing and evolving system such as healthcare, the two are intimately linked and equally necessary. Often the titles

and job descriptions for roles, particularly for those practitioners combining them with practice, do not reflect the relative proportions of leadership and management that are required.

- 11.18 Within the broad scope of management, **professional or clinical management** can be defined as management of the technical side of the job the staff member is trained to do, and line management can be defined as the administrative and operational aspects of the job. For example, it is now usual for the nurse director to be the professional manager/lead for the nurses in the organisation, but for line management to be exercised through the operational management hierarchy, and this model is also being adopted in respect of the medical director and the psychiatrists in some trusts. The GMC produces guidance on *Management for Doctors*.⁷²
- 11.19 **Clinical leadership** (leadership by clinical practitioners) can be vested in one person in the team or in several (dispersed leadership) and is not the preserve of any one profession. The clinical leader(s) will be experienced, and will be acknowledged by the team to possess good judgement, a sound knowledge base and excellent communication skills. Such a person might lead discussions about complex clinical decision making, as well as about team-based innovations and improvements to quality of care. Clinical leaders will work alongside team managers to ensure that the relevant policies are enacted in the team, and to advise if there are problems in managing the workload.
- 11.20 A clinical leader operating at a different level, for example a clinical director, will not have individual clinical responsibilities as part of that role, but may be the person charged by the trust to discharge its responsibilities for providing quality care to the defined population.

Norfolk and Waveney Mental Health NHS Foundation Trust lead clinician responsibilities

The trust provides an example of how responsibility and accountability for a wider clinical leadership role (the equivalent of a Clinical Director role in other organisations) may be arranged.

The day-to-day accountability of lead clinicians is to the appropriate locality or service manager.

However, the supervisory responsibility for the professional clinical leadership in the organisation lies with the medical director. Lead clinicians will be part of a regular peer supervision group with the medical director.

This mirrors the approach within multi-disciplinary teams where line management is provided by the team manager, but individual practitioners receive professional supervision from an appropriately skilled clinician, according to their profession and/or role.

The lead clinician and locality/service manager form the leadership partnership for their relevant area of service.

- 11.21 The team manager (who may or may not come from a clinical background, and may or may not be undertaking some clinical practice) will have overall responsibility for managing the budgets and the workload capacity of the team, and ensuring it meets performance and governance standards. The team manager will undertake the day-to-day management of the team, such as dealing with absence, recruitment, complaints, the team base, etc.

⁷² www.gmc-uk.org/guidance/current/library/management_for_doctors.asp

Annex A: Advice from professional regulators on responsibility and accountability

General Medical Council

- A.1 *Good Medical Practice* (latest edition, November 2006) is the GMC's core guidance for doctors and sets out the principles of good practice they are expected to adhere to. The GMC also publishes a range of other guidance that builds on the principles outlined in *Good Medical Practice* and provides advice on specific issues such as management, raising concerns about patient safety and prescribing. A full list of available guidance can be found on the GMC website.⁷³
- A.2 The GMC published *Accountability in Multi-disciplinary and Multi-Agency Mental Health Teams*⁷⁴ in October 2005 to specifically reflect NWW and the changes in accountability arrangements for consultant psychiatrists, and this is reproduced below:

Accountability in Multi-disciplinary and Multi-Agency Mental Health Teams

The Standards and Ethics Committee, working with the Department of Health and the Royal College of Psychiatrists has prepared the advice below to explain how the guidance on delegation and referral in *Good Medical Practice* applies to consultant psychiatrists working in multi-agency teams.

Consultants' roles and responsibilities are developing and changing. They vary according both to the specialty and the type of healthcare environment in which they are provided. Changing working practices, such as multi-disciplinary and multi-agency team work, and changes in the range of skills and competencies of other healthcare practitioners, present a number of opportunities as well as challenges in providing safe and effective care. Many of the issues are best resolved by clarity between consultants and their employing organisation about appropriate roles and responsibilities. Consultants should raise with their employing bodies any issues where ambiguity or uncertainty about responsibilities may arise. Consultants also need to be clear about the expectations of the GMC.

All doctors are accountable to the GMC for their conduct and the decisions they take. *Good Medical Practice* (2001) sets out the principles which should underpin their professional work and against which their conduct may be judged. *Good Medical Practice* does not try to address, in detail, all the circumstances in which doctors may work. This guidance explains how the principles in *Good Medical Practice* apply for doctors working in multi-disciplinary or multi-agency mental health teams.

1. Doctors should be competent in all aspects of their work including: reviewing and auditing the standards of the care they provide; training and supervising colleagues; and managing staff and the performance of the teams in which they work where and when they have direct line management responsibility.

⁷³ www.gmc-uk.org/guidance

⁷⁴ www.gmc-uk.org/guidance/current/library/accountability_in_multi_teams.asp

2. Doctors should do their best to ensure that the systems in which they are working provide a good standard of care to patients. Where doctors cannot be satisfied, nor take steps to resolve problems, they should draw the matter to the attention of their Trust or other employing or contracting body.
3. To these ends, doctors should establish clearly with their employing or contracting body both the scope and the responsibilities of their role. This includes clarifying: lines of accountability for the care provided to individual patients; any leadership roles and/or line management responsibilities that they hold for colleagues or staff; and responsibilities for the quality and standards of care provided by the teams of which they are a member. This is particularly important in circumstances in which responsibility for providing care is spread between a number of practitioners and/or different agencies.
4. Doctors are not accountable to the GMC for the decisions and actions of other clinicians.
5. This means that if a consultant delegates assessment, treatment and care to a more junior doctor, the consultant is not accountable to the GMC for the decisions or actions of the junior doctor but the consultant is responsible for ensuring that the junior doctor is appropriately trained, experienced and supervised.
6. Psychiatrists can delegate the care of those patients for whom they agree to take responsibility. But many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Instead, the multi-disciplinary teams of which they are a member may provide health and social care services to a substantial number of patients. Referrals are made directly to such teams and decisions about allocation to an appropriate professional are made according to the teams' policies. In these teams, the responsibility for the care of the patients is distributed among the clinical members of the team. Consultants retain oversight of a group of patients who are allocated to their care and are responsible for providing advice and support to the team. They are not accountable for the actions of other clinicians in the team. However, in accordance with paragraph 2, they must do their best to ensure that arrangements are in place to monitor standards of care, and to identify potential or current problems. They should notify their employer about any unresolved concerns or problems.

Nursing and Midwifery Council

- A.3 The NMC has published advice sheets on accountability (reproduced below)⁷⁵ and delegation⁷⁶ to a company *The Code: Standards of conduct, performance and ethics for nurses and midwives* (2008).⁷⁷

⁷⁵ www.nmc-uk.org/aDisplayDocument.aspx?documentID=4018

⁷⁶ www.nmc-uk.org/aArticle.aspx?ArticleID=3057

⁷⁷ www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=4184



Accountability

Nurses and midwives hold a position of responsibility and other people rely on them. They are professionally accountable to the NMC, as well as having a contractual accountability to their employer and are accountable to the law for their actions.

The Code says that:

"As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions".

and,

"You must always act lawfully, whether those laws relate to your professional practice or personal life."

If a nurse or midwife is asked to deliver care they consider unsafe or harmful to a person in their care, they should carefully consider their actions and raise their concerns to the appropriate person. Nurses and midwives must act in the best interest of the person in their care at all times.

If the nurse or midwife is delegating care to another professional, health care support staff, carer or relative, they must delegate effectively and are accountable for the appropriateness of the delegation. The Code requires that nurses and midwives must

- establish that anyone they delegate to is able to carry out their instructions
- confirm that the outcome of any delegated task meets required standards
- make sure that everyone they are responsible for is supervised and supported

Accountability is integral to professional practice. Nurses and midwives make judgements in a wide variety of circumstances. Nurses and midwives use their professional knowledge, judgement and skills to make a decision based on evidence for best practise and the person's best interests. Nurses and midwives need to be able to justify the decisions they make.

Further information

- The Code: Standards of conduct, performance and ethics for nurses and midwives (2008)
- NMC advice sheet on Delegation

This advice was last updated in April 2008.
For more information email advice@nmc-uk.org or call 020 7333 8333.

General Social Care Council

A.4 For the codes of practice for social care workers and the employers of social care workers, see the website.⁷⁸

Health Professions Council⁷⁹

A.5 The HPC regulates the following health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists/orthotists, radiographers and speech and language therapists.

A.6 It sets standards for these professionals in the domains of:

- character
- health
- proficiency
- conduct, performance and ethics
- continuing professional development
- education and training.

British Psychological Society⁸⁰

A.7 Statutory regulation by the HPC has been present since July 2009. The BPS has a system of voluntary regulation and a *Code of Ethics and Conduct*.⁸¹

A.8 See also:

- *Working Psychologically in Teams* (full document and summary)⁸²
- *Organising, Managing and Leading Psychological Services*⁸³
- *Generic Professional Practice Guidelines* (revised 2008).⁸⁴

Royal Pharmaceutical Society of Great Britain⁸⁵

A.9 The RPSGB is the regulatory and professional body for pharmacists in England, Wales and Scotland. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation.

A.10 As a result of the Government's White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (2007) – which signalled a commitment to separating regulation from professional leadership in all the health professions – a new regulator, the General Pharmaceutical Council (www.pharmacyregulation.org) will be set up in 2010. In parallel, a new professional leadership body for pharmacy will also be established.

⁷⁸ www.gsc.org.uk/codes/Get+copies+of+our+codes

⁷⁹ www.hpc-uk.org/aboutregistration/standards/

⁸⁰ www.bps.org.uk/

⁸¹ www.bps.org.uk/the-society/code-of-conduct/code-of-conduct_home.cfm

⁸² [www.bps.org.uk/document-download-area/document-download\\$.cfm?file_uuid=12B7C9B9-1143-DFD0-7E1C-75AEDF90F941&ext=pdf](http://www.bps.org.uk/document-download-area/document-download$.cfm?file_uuid=12B7C9B9-1143-DFD0-7E1C-75AEDF90F941&ext=pdf)

⁸³ [www.bps.org.uk/document-download-area/document-download\\$.cfm?file_uuid=12F185E0-1143-DFD0-7EE4-AF2913E5AFF0&ext=pdf](http://www.bps.org.uk/document-download-area/document-download$.cfm?file_uuid=12F185E0-1143-DFD0-7EE4-AF2913E5AFF0&ext=pdf)

⁸⁴ www.bps.org.uk/publications/prof-pract/prof-pract_home.cfm

⁸⁵ www.rpsgb.org.uk/

A.11 The RPSGB produces a *Code of Ethics for Pharmacists and Pharmacy technicians*, supported by nine supporting professional standards and guidance documents.⁸⁶

UK Council for Psychotherapy⁸⁷

A.12 The UKCP is a national regulatory and a professional body for psychotherapists in the UK. It also regulates psychotherapeutic counsellors on a voluntary basis. Regulation is expected to become statutory under anticipated legislation, with the HPC as the regulator. The UKCP will remain and develop as an internationally recognised professional body for psychotherapeutic work. The UKCP is a member of both the European Association of Psychotherapy and the World Council for Psychotherapy.

A.13 The HPC published its conclusions on the proposed statutory regulation of psychotherapists and counsellors in December 2009.⁸⁸

A.14 The UKCP has a Code of Conduct and Ethics for psychotherapists and psychotherapeutic counsellors, supported by professional standards and guidance documents.⁸⁹

Non-professionally affiliated workers

A.15 There is at present no regulatory body for non-professionally affiliated workers who carry out a wide variety of roles and have different titles. The Royal College of Nursing, the Royal College of Speech and Language Therapists, the British Dietetic Association and the Chartered Society of Physiotherapy have collaborated to produce *Supervision, accountability and delegation of activities to support workers: A guide for registered practitioners and support workers*.⁹⁰

⁸⁶ www.rpsgb.org.uk/protectingthepublic/ethics/

⁸⁷ www.psychotherapy.org.uk/

⁸⁸ www.psychotherapy.org.uk/hpc_announcement.html

⁸⁹ www.psychotherapy.org.uk/c2/uploads/ukcp%20ethical%20principles%20and%20code%20of%20professional%20conduct.pdf

⁹⁰ www.rcn.org.uk/__data/assets/pdf_file/0006/78720/003093.pdf

Annex B: Case law – legal test of responsibility for the standard of care

The Bolam test

- B.1 Mr Bolam tried to sue Friern Hospital Management Committee for negligence in 1957, after he was given electro-convulsive therapy without a muscle relaxant and suffered adverse effects including fractures. The second paragraph of the Judge's direction has come to be known as the Bolam test.
- 'I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.'
- B.2 The standard of care provided is not assessed with the benefit of hindsight but instead looked at on the basis of what the medical professional knew or should have known at the time the treatment was provided. Furthermore it refers to 'ordinary' doctors; it is not necessary to have the degree of knowledge of, say, a leading researcher in the field.
- B.3 The general opinion is that although this 50-year-old judgment refers to doctors (or actually 'medical men') it is applicable to all professionals. The test was altered somewhat by the case of *Bolitho v. City and Hackney Health Authority*, 1997.⁹¹
- B.4 In the case of *Bolitho*, the House of Lords decided in effect that if the management by a body of responsible doctors was not demonstrably reasonable it would not necessarily constitute a defence. If professional opinion called in support of a defence case was not capable of withstanding logical analysis, then the court would be entitled to hold that the body of opinion was not reasonable or responsible, that is a case cannot be defended on the basis of a current practice that is not reasonable or logical.

⁹¹ www.parliament.the-stationery-office.com/pa/ld199798/ldjudgmt/jd971113/boli01.htm

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List of abbreviations

AC	Approved Clinician
ACP	Association of Child Psychotherapists
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BACP	British Association for Counselling and Psychotherapy
BMA	British Medical Association
BPC	British Psychoanalytic Council
BPS	British Psychological Society
CCTA	Creating Capable Teams Approach
CMHT	Community Mental Health Team
CPA	Care Programme Approach
DOLS	Deprivation of Liberty safeguards
GMC	General Medical Council
GP	General Practitioner
HPC	Health Professions Council
IMCA	Independent Mental Capacity Advocate
MCA	Mental Capacity Act
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NMC	Nursing and Midwifery Council
NWW	New Ways of Working
PCT	Primary Care Trust
RC	Responsible Clinician
RMO	Responsible Medical Officer
RPSGB	Royal Pharmaceutical Society of Great Britain
STR	Support, Time and Recovery worker
UKCP	United Kingdom Council for Psychotherapy



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