Economic evaluation of the role of the non-medical Approved Clinician

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Introduction

The purpose of this economic assessment is to demonstrate the value of a non-medical Approved Clinician for an inpatient learning disability service in the south west of England.

The non-medical Approved Clinician (AC) role

In 2007 the Department of Health produced the document 'New Ways of Working for Everyone'. This promotes developing and sustaining a more flexible workforce within mental health services (Department of Health 2007a). The Mental Health Act, 1983 (MHA) was amended by the Mental Health Act, 2007. These amendments were enacted in November 2008. This has led to clinicians undertaking a broader range of functions (Department of Health 2007b) including Approved and Responsible Clinician roles for non-medical professionals.

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

> 'A person approved by the Secretary of State or by the Welsh ministers to act as an Approved Clinician for the purposes of this Act'

In England the function of approving ACs has been delegated to regional Approvals Panels. All applicants are required as a minimum to attend a two-day training course approved by the Secretary of State. The process also includes the development of a portfolio that meets the requirements of the regional Approvals Panel.

The role is open to a healthcare professional (specifically nurses, occupational therapists, psychologists or social workers) who is competent to become responsible for the treatment of mentally disordered people compulsorily detained under the Act. The Responsible Clinician (RC) role is to oversee and ensure effective co-ordination of a person's treatment and case management whilst they are subject to the Mental Health Act.

All Responsible Clinicians must be Approved Clinicians. The roles of a Responsible/Approved Clinician are outlined in appendix one.

These responsibilities form only part of the job description for the Approved Clinician non-medical in the same way as they form only part of the job description of a Consultant Psychiatrist.

Background

There are currently staffing challenges within learning disability services across England. This includes the recruitment of Consultant Psychiatrists in learning disability and the recruitment and retention of other staffing groups, of particular concern Learning Disability Nurses.

The development of Approved Clinician non-medical roles aims to alleviate some of the difficulties in recruiting psychiatrists by looking to other professional groups. New Ways of Working (Department of Health 2007a) was not about cutting the number of Consultant Psychiatrists; however there was acknowledgment that due to, 'an ageing population and significant numbers of staff approaching retirement, alternate ways to meet the continuing rise in expectations and demand'(p29) were required.

There was further recognition that, 'in addition, there is more pressure on costs, and staff, therefore, have to be used more effectively to provide value for money' (p29).

Organisational Support

Within Devon Partnership Trust an Approved Clinician development task and finish group has been established with dedicated project management time. Approved Clinician roles are being developed in several mental health and learning disability services. There is executive level support for these developments.

As part of the work of this group a scoping exercise was undertaken to establish where else in the country had developed roles and to look at the professional backgrounds of practicing Approved Clinicians. In 2017, it was not possible to identify any Approved Clinicians currently working in learning disability services. Currently the majority of ACs work in the north of England and the professional background is as below:

Table 1 Distribution of Approved Clinicians (non-medical) 2017

PANEL AREA	PSYCHOLOGISTS	NURSES	OTs	SOCIAL WORKERS	TOTAL
North of England	13	9			22
Midlands and East	3	3		1	7
London	4				4
Winterhead (S.East/S.West)	3	1		1	5
TOTAL	22	13	0	2	37

Since this information (2017) was provided to the task and finish group, a further study has been published (Oates et al 2018) identifying that currently there are 56 Approved Clinicians from a non-medical background working in England and Wales; of these at least 9 identify themselves as specialising in learning disability work. The majority of these practitioners remain in the north of England. The full distribution of practitioners was not published as part of the results.

Professional Bodies support for non-medical Approved Clinician roles

The Royal College of Nursing and the Royal College of Occupational Therapists make no specific reference to AC roles and offer no guidance to members regarding the appropriateness to undertake these. Similarly there is no specific guidance for social workers wishing to undertake these roles.

The Royal College of Psychiatrists makes specific note that future roles for learning disability psychiatrists need to embrace leadership roles and look to influence systems. There is concern regarding future availability of learning disability psychiatrists as previously described however solutions including non-medical ACs are not explicitly indicated.

The British Psychological Society provides more extensive guidance and suggests that Clinical Psychologists are well placed to become ACs and identify the potential benefits as:

- the ability to influence systems from a different perspective
- psychological understanding of systems and group behaviour
- embedding psychological formulation within decision making and risk assessment
- greater promotion of therapeutic risk taking
- psychological understanding to inform decision makers and
- best fit for people who require psychotherapy as their primary treatment

(British Psychological Society 2017)

Context

The context to this economic study is not only a lack of consultant psychiatry provision but the need to improve the recruitment and retention of learning disability professionals and the requirement to deliver quality services whilst meeting annual cost improvement programme targets.

Recruitment of Consultant Psychiatrists has been increasingly difficult within Devon and over the past three years the number of permanent Consultant Psychiatrists in Learning Disabilities has reduced (the number of posts remains the same, the vacancy rate has increased). Currently there are two vacant full time posts and a further vacancy which is being covered from existing resources. It has not been possible to recruit to these posts despite an active campaign. It has been necessary to employ agency Consultant Psychiatrists to cover shortfalls in service provision. It has also led to existing Consultant Psychiatrists taking on additional work and being 'stretched' across the inpatient and community learning disability service.

There is a requirement to make savings within services on an annual basis whilst maintaining and striving to improve the quality of services provided. These cost improvement programmes are developed at the start of each financial year and the implementation of the non-medical AC for learning disabilities has been identified as a potential recurrent cost improvement without detriment to the quality of service delivery.

The opportunities for career development to senior clinical posts have been limited for some groups of non-medical staff. Clinical career pathways for learning disability nurses, social workers and occupational therapists groups have historically not been well developed locally. Within the Trust professional development strategies are in place for each of these groups. The development of very senior clinical roles forms part of these strategies for professions.

Purpose of the economic assessment/ drivers

Drivers

In addition to the local context there is a shortage of Learning Disability Consultant Psychiatrists throughout the UK. The Centre for Workforce Intelligence (2014) stated that psychiatry of learning disability is one of the specialities 'most at risk of undersupply' (p 48) and the Royal College of Psychiatry note that there are 'real recruitment issues and small training numbers (which) all present challenges locally and nationally' (cited in Health Education England 2015 p35).

This national and local shortage also reflects the position for learning disability nursing professionals. There has been increasing national focus on the recruitment and retention of learning disability nurses. At a recent Health Education England event (15 May 2018), 76 delegates discussed the current challenges and identified work which needs to be done, with a recognition that a 'skilled and flexible nursing workforce is incredibly important' and that there needs to be career pathways and progression which is not just about going into management' (Health Education England 2018). Further national forum events are planned in 2018.

The number of NHS learning disability nurses has reduced by over 1000 between 2012 and 2017. The vacancy rate for learning disability nurses was estimated at 16% in 2017, the highest for all nursing groups. Nationally nurse trainees have reduced over the past five years due to difficulties in recruitment and due to the introduction of student loans (Health Education England 2017). Locally learning disability services reflect the national difficulties in recruitment of learning disability nurses. There are particular issues in Devon as there is no local training school providing learning disability nurse training and there is an ageing population of practicing nurses eligible to retire within the next five years. Recruitment to remote rural areas is challenging. Career pathways have not been explicit and historically there have been no advanced nurse practitioner or consultant nurse posts within the service which may have impacted on retention of staff.

There has not been the same issues locally for the recruitment and retention of occupational therapists or clinical psychologists in learning disability services.

The Service

The learning disability service provided by Devon Partnership Trust covers the whole of Devon (excluding Plymouth) and was redesigned and launched in April 2015. The service covers a primarily rural area. Approximately 180 staff are employed within learning disability services and vacancy rates within learning disability services run at approximately 10% (a mixture of professional roles).

There are five core service elements; these include a 5 bedded inpatient Additional Support Unit, an Intensive Assessment and Treatment Service (4 multidisciplinary teams based across 7 sites), Acute Liaison Service (3 District General Hospital sites), Primary Care Liaison Service and a Continuing Health Care service (3 teams).

There are no traditional Community Learning Disability Teams in Devon. There has been an increasing emphasis within services in Devon and nationally to facilitate mainstream services to make reasonable adjustments for people with learning disabilities. This is the focus of the work from both the Acute Liaison and Primary Care Teams.

The Intensive Assessment and Treatment Teams work with adults with mental health needs, challenging behaviour or complex physical healthcare needs. These teams are multidisciplinary in nature and consist of a range of therapists, psychologists, nurses and psychiatrists. A similar skill mix works within the inpatient service.

When learning disability services were redesigned there were few clinical posts above band 6 apart from professional leads. There were no purely clinical band 7 posts or above (apart from psychiatry and psychology) embedded within learning disability teams. Career development was reliant on practitioners wishing to step into management/leadership roles. There are no nurse consultant learning disability posts in Devon and no clinical band 7 nurses situated within learning disability teams. This differs to some other parts of the UK.

The Inpatient Setting

The Additional Support Unit has 5 beds and admits adults with learning disabilities who have additional mental health needs which cannot reasonably be met in a mainstream acute mental health inpatient unit. The patients in this setting are usually detained under a section of the Mental Health Act. The patients are supported by a multidisciplinary team comprising registered learning disability nurses, registered mental health nurses, assistant practitioners, support workers, assistant psychologists, clinical psychologists, consultant psychiatrist, speciality doctor, speech and language therapist, occupational therapist and physiotherapist. Current developments include the implementation of the positive behavioural support (PBS) model and the recruitment (in planning) of a social worker to support timely discharge from the unit.

Historically on the unit patients have had long stays and the aim with the support of the Transforming Care Partnership is to unblock beds and deliver an acute inpatient learning disability service with timely admission and discharge. There are weekly multidisciplinary meetings which are not consultant led and involve all members of the multidisciplinary team, the individual with learning disabilities and their family.

Service Direction

A key element of the work which multidisciplinary teams are involved in across learning disability services is to meet the STOMP (Stop Overmedicating People with Learning Disabilities) agenda. Locally, consultant psychiatrists are focussed on ensuring that people with learning disabilities only receive medication if it is clearly clinically indicated. There are opportunities for the development of non-medical prescriber roles to support this and is a service development which again supports the clinical development of professions (nursing and pharmacy).

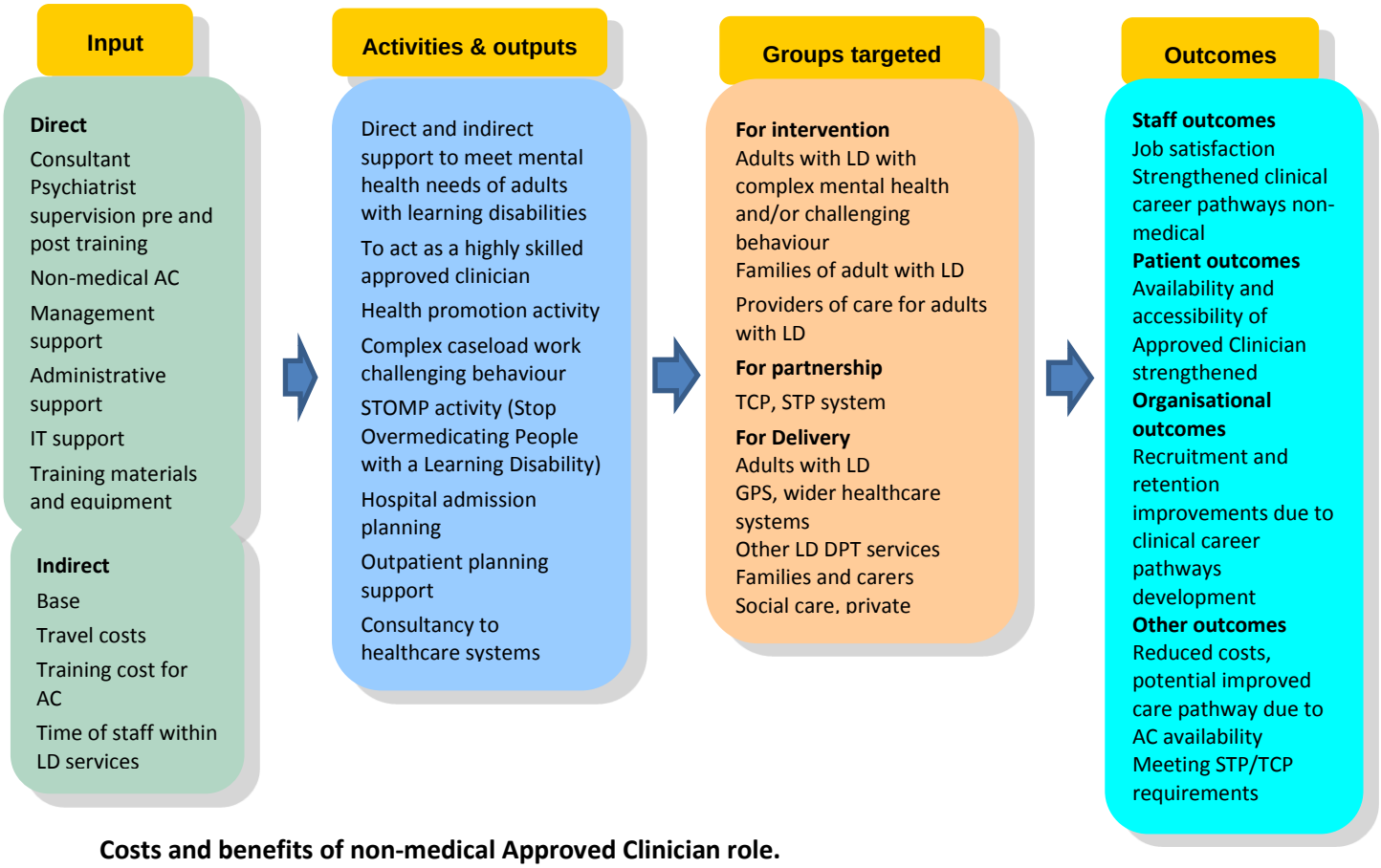
Locally, the Trust is actively engaged in the Transforming Care programme which sits as a work stream of the local Sustainability and Transformation Plan**.** Capacity and flow through the additional support unit are seen as vital to supporting people with learning disabilities to stay close to home. There are various initiatives to support this and an additional workforce strategy to ensure a fit for purpose and sustainable market of both NHS, social and private care providers. There is support for the development of new roles to support the delivery of the work locally.

Pathways to Outcomes

The following pathways to outcomes model (figure 1) identifies the inputs, activities and outputs, stakeholders and outcomes which are anticipated in the implementation of the Approved Clinician project.

Figure One - Pathways to Outcomes Model

Non-Medical Approved Clinician: Pathways to Outcomes Model



Costs and benefits of non-medical Approved Clinician role.

There are very few key financial costs involved in setting up and implementing the development of the non-medical AC roles, as within the Additional Support Unit this will be instead of a Consultant Psychiatrist post. Apart from training and supervision there will be no additional costs which would not already and normally be associated with a Consultant Psychiatrist working in the Additional Support Unit. The costs and benefits are presented in table two.

Table Two: Costs and Benefits Overview

Cost	Benefit
1 x 8c Non-medical Approved Clinician post	There are significant difficulties in recruitment of Consultant Psychiatrists, leaving vacancies across the learning disability service This leads to the overstretching of the existing Consultant Psychiatrists and the need to employ consultant locum psychiatrists at the same cost as a full time consultant psychiatrist but for a reduced number of hours due to the higher hourly rate. The development of a non-medical AC role ensures service delivery as needed for adults with a learning disability in the local area with more timely access due to greater availability. There are opportunities for strengthened clinical career pathways leading to lower turnover and better retention of staff. This also contributes to long term lower recruitment costs making organisational savings.
Training programme for non-medical Approved Clinician	The Approved Clinician role for a non-medical person has to be approved and following the programme of training will ensure an approved, fit for purpose clinician

Key benefits

The benefits of the development of a non- medical Approved Clinician within learning disability services have been identified in table two as those that benefit staff, those that benefit the individual patients and those that benefit the organisation.

Staff benefits

''The extended roles of AC/RC to professions other than medicine is a statutory manifestation of New Ways of Working. The overarching potential benefit is the enhanced clinical leadership within the multidisciplinary team (Ledwith et al 2017).

In a recent survey carried out in England and Wales by Oates et al (2018) those working as ACs identified that the key benefits for them personally were enhanced professional roles and support for professional development where they were able to use their expertise and experience.

Patient benefits

The implementation of the non-medical Approved Clinician role reduces the likelihood of any patients waiting to see either an overstretched psychiatrist or a locum psychiatrist with whom they are unlikely to establish a long term relationship due to the transient nature of many locum roles. Consultant psychiatrists will have more time available to focus on community work and supporting the intensive assessment and treatment teams working to prevent hospital admissions as part of Transforming Care requirements. Within the Additional Support Unit a positive behavioural support approach is implemented with many of the patients. The availability of a non-medical Approved Clinician with specific skill and experience in this area potentially enhances the value of the non-medical role in the setting. Additionally the non-medical Approved Clinician will be based on the Additional Support Unit and not also covering a community caseload, providing better visibility and accessibility.

Organisational benefits

The main driver within the local organisation is the sustainability of services on a long term basis whilst reducing costs and potentially enhancing overall service quality (by availability of more staff). Demonstrating a commitment to clinical career pathways to a senior level for non-medics increases the attractiveness of the organisation as an employer.

Benefits and success expected by non-medical AC task and finish group (Trust)

Within the project initiation document for the Trust key indicators for success were identified as:

- Providing patient safety
- Promoting a more flexible workforce
- Quicker decision making to meet patient need
- Improved multidisciplinary working practice (reduced use of anti-psychotics)

The Approved Clinician roles are expected to deliver improved/ positive patient experience and deliver effective care. There will be new models of clinical leadership as a result of increasing the diversity of AC/RC clinicians. There will be full utilisation of the skills of health care professionals. There will be improved clinical outcomes, length of stays and medication optimisation with a reduction in polypharmacy.

System Benefits

STP/TCP confidence in the sustainability of the learning disability service delivery model leading to confidence from commissioners in the ability of the learning disability organisation to deliver high quality, safe and effective services.

Potential Risks

There are no identified additional risks to quality and service delivery within the Additional Support Unit as the service is multidisciplinary in nature and the non-medical approved clinician would receive support from a consultant psychiatrist. There wouldn't be a risk to quality and safety as the role of the approved clinician is developed as current arrangements would remain until the non-medical approved clinician had completed their portfolio training. Within learning disability services the resource is under pressure. By developing a non-medical approved clinician this not only reduces the pressure to appoint Consultant Psychiatrists but presents the opportunity for the Consultant Psychiatrist currently working into the Additional Support Unit to be released to cover shortfalls in community services. The requirement of the Consultant for ASU would be residual requiring some hours to provide supervisory support to the AC in training and on-going (please see set up and running costs tables three and four).

Monetised Costs

Table Three: Set up Costs non-medical Approved Clinician

Direct	**Identify**	**Quantify**	**Monetise**
1.	Staff	1 WTE band 8c non-medical AC	£79,653
2.	Training	Attendance at portfolio training Approved Clinician induction training (Somerset) Travel Exeter to Somerset, 2 days - 264 miles	£95 + VAT= £114 £375 + VAT=£450 264 miles x0.56pence mileage rate = £147.84
3.	Supervision	1 hour per week from Consultant Psychiatrist during 12 month portfolio development	4 x 12 hours = 48 48 x £55.18 = £2,648.64
4.	Administrative support	0.5 WTE band 4	No additionality
5.	Equipment	1 laptop	£1,200
6.	Working space	Office and clinic rooms	No additionality
7.	Prescribing	Drugs budget	No additionality
Total			**£84,213.48**

The costs shown in table three are for the first year. This is the expected timeframe for the completion of portfolio training. During this time Consultant Psychiatrist cover for the Additional Support Unit would remain as it is currently with the resource being stretched across both inpatients and community. There would be no additionality.

The clearest element to monetise is the direct cost comparison of an Approved Clinician (non-medical) once trained and 'running' compared to an Approved Clinician (medical) 'up and running'. The difference in economic terms is the difference between an 8C post and a Consultant Psychiatrist post. A comparison could also be made that when we do not have people in post we employ locums on the same monies as a full time Consultant Psychiatrist but this only stretches to part-time cover, with a potential reduction in service quality for the patient.

Table Four: Annual running cost - Direct Cost Comparison - salary and supervision support

Cost type	Approved Clinician (non-medical) Band 8c	Approved Clinician-Consultant Psychiatrist	Approved Clinician Agency locum Consultant Psychiatrist
Annual salary Whole Time Equivalent (mid-point with on-costs)	£40.47 per hour (£32.23 basic plus NI, pension, PAYE) Full year £79,653	£55.18 per hour (£41.41 basic plus NI, pension, PAYE) Full year £115,080	£87.50 per hour (includes on-costs) Full Year costs £182,484
Medical supervision 2 hours per month	£55.18 x 2 £110.36 Annual cost £1,324.32 (£110.36 x 12)	N/A	N/A
Total Annual cost	£80,977.32 (1 x FTE)	£115,080 (1 x FTE)	£182,484
Cost saving per annum		+£34,102.68	+£101,506.68

The cost saving £34,102.68 is a recurrent one contributing to the recurrent cost savings required by the learning disability service.

The set up cost £84,213.48 is only slightly higher than the on-going cost £80,977.32 due to the training element required and the additional supervisory support.

For the purposes of comparison the full time equivalent costs have been shown for a locum Consultant Psychiatrist. Within services Locum Psychiatrists tend to be used on a part-time basis and the full locum cost would not be spent.

Conclusion

This economic assessment of the implementation of an Approved Clinician role has presented the background to the current recruitment challenges within the learning disability service locally (reflecting the national picture). It has then provided a rationale explaining that there is no risk to quality by implementing a change to traditional approved/responsible clinician practitioners. There is no evidence to suggest that there are any risks to service delivery quality and in general terms there is some evidence that the implementation of this role could improve quality in some areas. The economic evaluation demonstrates that not only does quality remain uncompromised but there are potential recurrent financial savings to the organisation whilst additionally releasing consultant psychiatry time to focus on complex community patients.

References

Centre for Workforce Intelligence (2014) *In-depth review of the psychiatrist workforce main report*. Available from http://assets.publishing.services.gov.uk. Accessed on 18/07/18.
Department of Health (2007a). *Mental Health: New Ways of Working for Everyone: Developing and Sustaining a Capable and Flexible Workforce.* London, Department of Health.
Department of Health (2007b) *The Mental Health Act (2007)*. London, Department of Health.
Department of Health (2007c), *New Ways of Working for Everyone: A best practice implementation guide*. London, Department of Health.
Health Education England (2015) *HEE Workforce Planning and Strategic Framework (Framework 15)* Available from http://www.rcpsych.ac.uk. Accessed on 18/07/18.
Health Education England (2018) *Health Education England Learning Disability Nursing*. Available from http://www.hee.nhs.uk. Accessed on 12/07/18.
Ledwith, S,. Todd, N., Gillmer, B. and Taylor, J. (2017) *Clinician frequently asked questions*. Available from http://www.bps.org.uk. Accessed on 20/07/18.
Oates, J., Brandon, T., Burrell, C., Ebrahim, S., Taylor, J.and Veitch, P. (2018) *Non-medical approved clinicians: Results of a first national survey in England and Wales*. International Journal of Law and Psychiatry, Vol 60 pp 51-56.

Appendices

Appendix One

Powers of a Responsible Clinician under the Mental Health Act

Clinical lead for a patient liable to be detained or on a Community Treatment Order (CTO) or guardianship:

- Granting section 17 leave
- Reviewing need for detention, CTO or guardianship
- Discharging from detention, CTO or guardianship
- Deciding whether to bar nearest relative discharge from detention or CTO
- Renewing detention, CTO or guardianship
- Recommending transfer to guardianship
- Making a CTO (with Approved Mental Health Practitioner)
- Recalling from CTO
- Revoking CTO (with AMHP)

Reporting to Minister of Justice on restricted patients

Powers of an Approved Clinician when not a Responsible Clinician;

The Approved Clinician (or doctor) in charge of the treatment of an informal patient is the one with the power to prevent a patient from leaving under Section 5(2):

- may be authorised under Section 24 by NR to visit and examine a patient in private
- may be authorised for Tribunal report to visit and examine a patient in private
- may be authorised by the Care Quality Commission (CQC) to visit and examine a patient in private
- may provide reports to Court in some Part 3 cases

These responsibilities form only part of the job description for the Approved Clinician non-medical in the same way as they form only part of the job description of a Consultant Psychiatrist.