

The non-professionally affiliated workforce in mental health – who are these generic mental health workers and where do they fit within a workforce strategy?

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Abstract

This paper gives an overview of the 'non-professionally affiliated' (NPA) workforce in mental health in relation to their education, training and development. Some comparison is made with the current situation for the key professions in mental health. We argue that the NPA workforce is an increasingly significant and important part of the workforce and that attention needs to be paid to the construction of an overall development and qualification pathway for these workers, who embody many of the strengths of generic mental health work and have been found to be of great value to service users and their families.

Key words

mental health workforce; education and training; development pathways; non-professionally affiliated workers; new roles and new ways of working

Introduction

The 21st century has seen a major boost to both the status and number of mental health workers who do not belong to a specific profession. These workers have come to be known as 'non-professionally affiliated' (NPA) workers in that they do not have a recognised qualification from the professions that are most active in mental health – nursing, occupational therapy, psychiatry, psychology and social work. Sometimes they are also referred to as 'unqualified' although, as we will explore in this paper, they increasingly do have qualifications. They can also be called 'generic' mental health workers in that they are not constrained by a specialist role as the professions may be.

The common use of the term 'unqualified workers' reflects the historic low status of these workers in mental health services and, although valued for their direct work with service users, this rather dismissive category may suggest that they have been seen as unthreatening to the established order. Attitudes may be changing, as the closure of the majority of the large Victorian psychiatric hospitals in the latter part of the 20th century witnessed an increasing blurring of professional roles, increased calls for more generic workers and a suggestion that the different professionals are doing more or less the same job (Muijen, 1997; SCM, 1997a; Basset & Corrigan, 2002). The existence of generic workers and promotion of these roles may therefore become a challenge to the professions.

The NPA workforce has recently been boosted by new workers, such as support, time and recovery (STR) workers, who are part of the modernisation agenda in mental health in England. These new roles are currently receiving considerable attention, but it must be emphasised that there has always been an extensive NPA workforce encompassing roles such as residential worker, day-centre worker, support worker, telephone helpline worker, health care assistant, home carer, technical instructor and recreational therapist. These roles certainly grew considerably as the large hospitals closed. The roles are in all sectors – in the NHS, social services and in the voluntary/independent sector as well as in housing associations.

It is difficult to access accurate data on the total numbers of NPA workers in the UK for a number of reasons including the wide range of roles in which they are employed, the variation in job titles and different methods for gathering information. For example, the overview of staff numbers within the NHS in

England 2005 published by The Information Centre (2006), part of the Government Statistical Service, has categories described as 'support to doctors and nurses' and 'support to scientific, therapeutic and technical staff'. The figures for these groups include mental health support workers and health care assistants working in mental health settings, but they also include clerical and maintenance staff. An exercise to collate information from sources in Scotland, Wales, Northern Ireland and England would be further complicated by differences in systems and structures. For example, Skills for Health has a structure to encompass the whole UK but there is Skills for Care in England and Skills for Care & Development in Northern Ireland.

Aside from the difficulties of collating information from a wide range of different sources there are also issues regarding which roles to include or exclude. For example, should we include workers who provide carer support or home care workers who work with other groups in addition to people with mental health problems? Such information would be helpful for workforce development planning, but we may be some way off having a clear picture. However, it is widely acknowledged that the non-professionally affiliated workforce is larger in numbers than any of the individual professions. Currently, mental health nurses form the largest professional group with the number of 47,000 across England being quoted in *From Values to Action: The Chief Nursing Officer's review of mental health nursing* (DoH, 2006). However, a recent Sainsbury Centre report (Boardman & Parsonage, 2007) estimated that 73,453 NPA workers would be needed by 2010/2011 for the *National Service Framework for Mental Health* (DoH, 1999) to be fully implemented. This compares with similar figures estimated for mental health nurses (70,790) and a much lower number of 10,211 social workers.

Training and education for non-professionally affiliated workers has recently received a lot of attention with the development of a number of new courses, awards and initiatives. However, the current situation is that there are no clear developmental and career pathways for most NPA workers unless they enter a professional training programme. Education and training are dominated by the 'twin peaks' of nursing and social work, and these professional roles are seen as the pinnacle of achievement because they provide decent pay, promotion opportunities, security and status. Yet despite this the

National Mental Health Workforce Strategy (NIMHE, 2004) includes the aims:

- to facilitate **new ways of working** across professional boundaries; to make better use of specialist staff to meet the needs of service users and carers
- to create **new roles** to tap into the recruitment pool and complement existing staff groups.

In a nutshell, the professions are being asked to look at working differently and in new ways, and NPA workers are being recruited to complement the work of the professionals. Much constructive work has been done on both fronts. The current challenge is to bring all this work together into an integrated system so that all workers can work in a complementary and co-operative way.

In this paper we will discuss issues in relation to the 'non-professionally affiliated' workforce, consider their potential development pathways and argue that they need to be supported in delivering a vital part of mental health services.

New roles and the contribution of the voluntary sector

There is a current focus on new workers as part of the modernisation agenda in mental health. Recent policy has spawned an increasing number of new workers, including community development workers for black and minority ethnic communities, primary care graduate workers, and support time and recovery workers. Indeed, we counted up to 21 new roles in the *National Mental Health Workforce Strategy* (NIMHE, 2004).

These roles have been, and are currently, scattered throughout statutory services and may be considered essential to the independent sector in mental health. It is important to state here that the voluntary sector in mental health has a long and distinguished record of both campaigning for, and increasingly, also providing community-based mental health services. Often in the past, the voluntary sector has been quite critical of statutory provision and has led the way in championing the provision of service user-centred approaches and services. Mind, Rethink, the Richmond Fellowship and the Mental Health Foundation, together with a host of smaller organisations have all made a significant impact. Since the closure of the large hospitals, the substantial contribution of many housing associations has also been part of this picture.

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The fact that the voluntary sector tradition is both longstanding and very often innovative, is perhaps best illustrated by Together, which in its former guise as the Mental After Care Association (MACA), was founded in 1879. Its founder, Henry Hawkins, had a vision of recovery that mirrors current government policy (Basset *et al*, 2006).

Given both the historical context and the current emphasis on recovery, it is important to be clear that the voluntary sector in mental health does a great deal of work that broadly could be called 'recovery'. This is not to say that the voluntary sector always gets it right, but more to flag up to the Department of Health that 'recovery' work is something that the voluntary sector knows a fair bit about. However, publishing the results of their work and promoting what they do has never been a great strength of this sector. It is interesting to see that this century has already seen MACA become 'Together – working for well-being' and the Richmond Fellowship adopting the strap line 'Making Recovery Reality'. We hope that such changes will be backed up soon by firm evidence that these organisations are putting their philosophies into practice.

Another key factor in relation to the NPA workforce in mental health is the finding that service users particularly appreciate the work they do and the way it is carried out. For example, the report *More than a Friend* (SCMH, 1997b) examined the role of the support worker in mental health and found them to be highly valued by service users. Often it is their 'ordinariness' that is appreciated and this may be considered an indirect challenge to the mental health professions who are perceived as having lost the ability to relate to service users as people rather than as patients.

Training and development initiatives

In the 1990s, the creativity, flexibility and ordinariness inherent in the NPA role led to concerns that in some organisations NPA workers were often working independently, with considerable responsibility and without adequate training and supervision. This was highlighted by some high profile 'failures' in care. The report of the inquiry into the death of Jonathan Newby (Davies *et al*, 1995), a volunteer for the Oxford Cyrenians, recommended the development of a core training syllabus for NPA workers. The inquiry found that the failure to train staff and volunteers was a factor that contributed to his killing.

Many organisations were, in fact, running excellent training and development programmes for NPA workers and some, such as the short courses offered by The Richmond Fellowship, were highly valued by employers and participants. Some organisations now add value to their programmes by linking them to local or national credit frameworks.

In the 1990s Scottish/National Vocational Qualifications (S/NVQs), based on national occupational standards, were becoming more established in social care settings, but had not yet made a significant impact in mental health. S/NVQs offer access to a qualification based on the assessment of competence within a particular work role against national occupational standards. Some mental health employers considered the awards inappropriate to mental health work because of the generalist nature of the units. This lack of any mental health specific S/NVQ awards and a paucity of substantial knowledge-based educational programmes led to the development of a selection of awards and qualifications, some local and some national. These include vocationally related qualifications (VRQs) such as the Level 3 Certificate in Community Mental Health Care (developed in a partnership between City and Guilds and the Mental Health Foundation) and academic awards such as the Richmond Fellowship Diploma in Community Mental Health and Middlesex University's BSc in Mental Health. Increasing numbers are accessing these qualifications. For example, in March 2006, over 6,000 candidates had registered for the level 3 certificate in community mental health care.

In recent years S/NVQs have been revised to include mental health specific units, and these are now considered essential qualifications for workers in social care settings such as home care and registered care homes, as they are likely to be tied in with the forthcoming registration and regulation of the social care workforce. There are S/NVQs at level 4 (managerial) that provide a framework for possible career development and progression. However, it is important to note that S/NVQs assess competence within a work role and therefore candidates need to obtain a level 4 position before undertaking the award. NPA workers who try and obtain such a post may find that their way is blocked by an organisational requirement that the post holder has a professional qualification. S/NVQs are well established in many parts of the health service and in

some areas they are used to enable health care workers to gain access to professional training. S/NVQ programmes can bring many benefits to organisations as they articulate a clear value base for almost every work activity and encourage candidates to reflect on their practice against national standards.

Despite welcoming these developments, employers, learners and training providers are now in a situation where there are different options and their decisions about which option to select are influenced by a number of (sometimes competing) factors. This has resulted in dilemmas in planning and allocating funding for the training of NPA workers. For example, an NHS based employer in England may have to take into account the requirements and recommendations of at least six different policies, frameworks, organisations and regulators, depending on the nature of the services they deliver. These may include Skills for Care, Skills for Health, The Commission for Social Care Inspection, The Health Professions Council, The General Social Care Council, The Knowledge and Skills Framework and Agenda for Change. In some cases what an employer may prefer for their own service is not acceptable because of a regulatory requirement that has not even yet fully emerged, leaving employers confused about what to do for the best.

The current situation now needs some attention so that awards and qualifications can be streamlined. Most importantly, an education and career pathway needs to be established for these workers, who are beginning to tell us in increasing numbers that they are confused as to whether they should seek either vocational or academic qualifications or possibly both.

The professions – developments towards a 'capable practitioner'

It is important also to acknowledge the position of the professions in mental health in relation to training, education and development pathways. The Sainsbury Centre has done much good work in this field, which started with the publication of *Pulling Together* (1997a) as an attempt to make some sense of a muddled situation and to make plans for the future roles and training of mental health staff. It was clear that the overlap of roles between professional staff was significant. Building on this and concentrating on the work that needed to be done, rather than the profession of the worker, the

Sainsbury Centre produced the *Capable Practitioner* (2001) and this explored the generic knowledge and skills needed for mental health work. Specialist work was then looked at in terms of both interventions and the service setting in which the intervention would take place. *The Capable Practitioner* was also mapped against the *National Service Framework for Mental Health* (DoH, 1999).

Subsequent work led to the development of the *Ten Essential Shared Capabilities* (DoH, 2004), which have been used as a basis on which to build the training and education of all mental health workers.

The professions have responded to *New Ways of Working* with various reviews and reports (for example Department of Health and Royal College of Psychiatrists, 2004).

The review of mental health nursing (DoH, 2006 p4) recommends that mental health nursing should:

- 'incorporate the broad principles of the Recovery Approach into every aspect of their practice. This means working towards aims that are meaningful to service users, being positive about change and promoting social inclusion for mental health users and carers'.
- 'take a holistic approach, seeing service users as whole people and taking into account their physical, psychological, social and spiritual needs'.

These are bold and good key recommendations. However, they seem to us to apply to all mental health workers and we would argue that the overlap between the professions still remains and there is now a tendency for all professions to head for the same ground. They are moving back towards listening to service users, respecting their perspective, acknowledging their strengths and engaging with them in meaningful therapeutic relationships. This reflects the broadening out of mental health work away from the preoccupation with medication as the only effective treatment. It also reflects a moving back to the basic therapeutic relationship with service users, which the professions had to a certain extent abandoned, and left to what has become known as the non-professionally affiliated workforce.

Those of us who work with this workforce are both pleased that the professions have made this move, but also nervous that the specific generic nature of the support worker will become imbued with the need to be special and different, that lies at the heart of all professions. We would also argue that it is not really

feasible for any of the mental health professions to claim to have a holistic approach. The very nature of the professions is to be specialist and different and they operate within a western medically dominated paradigm that is all about specialisms and at its root has a clear division between the physical and the mental. Of course, it can be argued that we are all working within this paradigm, but it seems to us that the NPA workforce has more opportunity to develop new generic ways of working that go beyond this paradigm. It is important, we feel, that the generic mental health role is supported in its own right, and this is one reason why we advocate for more attention and a greater status for the NPA workforce.

The current situation: opportunities and concerns

Over the last 10 years many employers have enthusiastically embraced the policy agenda in relation to developing a diverse, multi-skilled, non-professionally-affiliated mental health workforce. They have recruited people with varied life experiences from a wide range of backgrounds in line with a vision of a mental health service that supports people in their own homes, recognises different needs, provides choice and focuses on recovery. One clear advantage of this development has been that routes into mental health work have opened up for service users and carers who feel they have a contribution to make through their own expertise, and who have a passion and commitment to making a real difference to mental health services.

However, the diversity of the NPA workforce and the lack of clarity about development pathways for NPA workers present challenges for those responsible for planning training and development programmes. In planning with individuals it is necessary to take into account that NPA workers vary in three key ways:

- educational backgrounds and achievements
- previous work experience and competencies
- personal and career aspirations and goals.

It is normal for any group of learners, even those sharing the same job role, to have varied starting places and goals, but the active recruitment of a diverse group accentuates these differences. Although diversity is a positive asset, it is also an obstacle to neat and efficient planning, making the equitable allocation (of often

scarce) resources very difficult (see **example 1**). It may be managed more easily at induction and foundation levels, as these are primarily focused around establishing core principles and values, meeting legislative requirements and communicating standards for work activities. New teams may also allocate development time to agreeing norms and setting goals with input from 'specialists'. However, the difficulties often arise beyond the first year in the life of a new team or the first year of employment for a new worker when individuals begin to ask, 'what next?' In an environment where 'lifelong learning' has been actively promoted as essential to all, NPA workers have the right to ask their employers about options for their continuous professional development (CPD). However, workers may find that what is available does not meet their needs. This is not just a disappointment for the individual, as it may lead to problems in maintaining levels of motivation within teams and the retention of skilled practitioners.

Example 1

Sally is a support worker in a new recovery-focused team that consists of five NPA workers managed by an occupational therapist. She has a psychotherapy qualification and 15 years' experience of working in a day service that has now been closed down. The team has had an intensive induction over the first six months to establish their common values and approach, and now the manager is considering continuing professional development opportunities for all team members over the next year. The training manager explains that all funding for NPA workers has been allocated to the level 3 NVQ programme in health and social care, which includes a requirement to attend mentor sessions focused on the units. The majority of candidates on the programme are health care assistants from an acute admissions ward and a care home for older people, many of whom will be using the NVQ to help them access nurse training. Sally is offered an opportunity to apply for a place, but she refuses on the basis that the content of the programme is not appropriate for her work role and her level of educational attainment. She does not want to apply for a professional training such as nursing, as she is fully committed to developing alternative models of support.

As highlighted already, in addition to difficulties associated with the individual profile of learners, employers and training managers have to take into account a wide range of contextual factors when making decisions about how to distribute funding. These include:

- the local needs of services in relation to achieving quality standards
- the current expectation that all programmes will be competency based and outcome focused, and the way funding is tied to this
- the pressures arising from the ongoing reconfiguration of mental health services
- organisational objectives
- the demands of regulatory frameworks
- the variability of local education, training and qualifications provision in terms of access, cost and quality
- future workforce demands
- economic pressures such as restrictions on study leave and the need to provide minimum staffing levels.

This range of factors can lead to some difficult decisions about where to target interventions (see **example 2**).

Example 2

Kiri is a training manager in a voluntary agency. She has a target to enable 10 support workers to achieve NVQs each year in order to meet inspection requirements for the agency's care homes. However, she is also aware that there are concerns about the quality of practice in the homes and the negative attitudes of some of the workers. She does not feel that the service achieves the standards necessary to enable all candidates to demonstrate competence. Those that do achieve their award quickly move on because of their frustration with the environment. Kiri has investigated the Certificate in Community Mental Health Care and can see ways in which the programme could raise the standards of practice through enabling workers to explore their values and approaches, and be exposed to new ways of working. She would deliver the programme in a partnership with other local organisations and this could enhance opportunities for joint working. However, the managers insist on the NVQ programme and she has no other funding available.

The current situation may also lead to difficulties for training providers with regard to planning their future programmes and security of funding (see **example 3**).

Example 3

Two NHS mental health trusts work in partnership with a local college to develop a recovery focused training programme for their NPA workers, with places being shared equitably between the trusts and a proportion allocated to local voluntary sectors organisations. The programme is run for two years and achieves a high level of learner approval and the evaluation demonstrates that it is effective in improving practice and increasing the amount of co-operation between agencies.

However, funding for education and training in the NHS trusts comes mainly from the strategic health authority and is tied to specific targets and outcomes that may change each year. In the third year, a new target is introduced in relation to a different policy agenda and the funding for the programme is halved. The college cannot fill the remaining places and the programme is cancelled.

What would help and what are the ways forward?

Being optimistic, it could be argued that mental health services are in a period of transition. We may be moving from an established order with inflexible systems to a new situation where diversity is valued and creative solutions are possible within a supportive framework. At present, these two cultures exist alongside each other and they collide from time to time, leading to confusion and mixed messages. For example, we are encouraged to work creatively and be service user led, but in order to achieve career progression we must still sign up to one professional model. We encourage people to join us from all kinds of backgrounds, but eventually they must all obtain an NVQ. Guidance on the Skills for Care (England) website seems to reflect the frustration and upset that has arisen from these mixed messages:

'Some people have already undertaken training and gained certificates and qualifications that do not match the new requirements. These people have not wasted their time nor do they have a worthless

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certificate. They should identify the appropriate qualification for their work role and plan a learning and assessment process over the next few years.'

One can only imagine the angry phone calls and emails they must have received. The next section on their web page goes on to explain NVQs and does not mention any other options.

If we are in a transition process, then there will be both dangers and opportunities. Managers may allocate funding to programmes that do not meet regulatory requirements, and individuals may be discouraged by the lack of recognition for a qualification programme that they found to be stimulating and cutting edge. However, it is also an exciting time with new models and methods being developed.

Some organisations have already worked out a way of managing the complexity of the current situation while trying to anticipate future demands. For example, some employers offer a dual qualification of a S/NVQ and VRQ, using the latter as an underpinning knowledge programme and to provide some evidence towards the former. Others offer S/NVQs and VRQs as alternative options for individuals and attempt to ensure that overall they have sufficient numbers of people with S/NVQs to meet regulatory requirements. They recognise that individuals have different learning needs and preferences, and value the idea of being learner-centred and doing what is best for their particular organisation. Often these organisations use a continuous professional development tool based on individual profiling, objective setting, appraisal and personal development planning. It is usually completed in a yearly cycle and often there are a wide variety of development methods available including mentoring, coaching and shadowing, in addition to formal learning programmes.

The success of any learning and development intervention relies considerably on the situation, knowledge and skills of managers. In relation to planning interventions this includes:

- how much they know about what options there are and the strengths and weaknesses of each
- their knowledge of funding sources and alternative and supplementary sources
- whether they are constrained by local factors such as being tied to a higher education institution that is not employer focused

- their knowledge of best practice and appropriate content for a learning/qualification programme and their ability to judge the quality of a programme
- the degree of attention given to understanding learning needs, profiling of individual staff and their CPD
- their understanding and skills in relation to opportunities for work based learning
- their courage to take a risk and be committed to innovation and developing the NPA workforce.

Some of the problems faced by managers and developers could be addressed by interventions at a national level. For example, the following actions would be helpful:

- providing guidance and information on what options and alternatives are available and how they can be funded
- giving information on appropriate pathways in different situations and for workers with different profiles
- providing guidance on assessing the quality of development and qualification options
- supporting the development of promotion opportunities for NPA workers.

However, we think the emphasis should be on a supportive and informative response rather than a new set of rigid frameworks. We argue that the most forward thinking response, in the spirit of new ways of working, would be a clear and co-ordinated message from key organisations that alternative ways of developing NPA workers are acceptable, as long as each is accompanied by a considered and articulated rationale. Interestingly, with the current economic climate within mental health services, there seems to be an increasing expectation that all workers will take more responsibility for their own development, including partly funding it. In the end, if what is on offer is not acceptable, NPA workers may vote with their feet.

Conclusion

In this paper we have examined some of the impacts of new roles and new ways of working as the Department of Health seeks to make changes to the mental health workforce, so that it is better able to deliver on the modernisation agenda. Much progress has been made towards a more modern workforce. Inevitably, the mental health professions have looked at their roles separately.

The NPA workforce has been busy building itself up and adapting to the new roles that have been introduced. The current challenge is to bring all this work together into an integrated system. The recent *Mental Health Policy Implementation Guide* (DoH, 2007) with its strong emphasis on co-operation across organisations, departments and professions will help.

It is important that work to develop a framework for educational, training and qualification pathways for the NPA workforce is done quickly as the focus of attention and resources on mental health that came with the *National Service Framework* (DoH, 1999) will come to an end in 2009. In this climate all new initiatives will need to be much more self-sufficient to thrive and survive in 2009 and beyond.

If there is no real pathway for the NPA workforce, many of those who want to progress in their careers will inevitably pursue the route of professional training as a nurse, social worker or one of the other mental health professions. It could be argued that this is no bad thing.

However, we worry that the spirit and value-base that lies at the heart of generic mental health work, which has essentially grown out of mental health's innovative voluntary and independent sector, should not just become subsumed into the professions. It needs to survive as a way of working in its own right. If it hadn't been there in the 20th century, perhaps we would still be providing services from the large Victorian hospitals – after all many professional mental health workers were quite comfortable with this and found the transition to community care very difficult to make. We will also certainly need this spirit and value-base in the 21st century – just in case anybody gets the idea that going back to providing services from large institutions is a good thing.

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