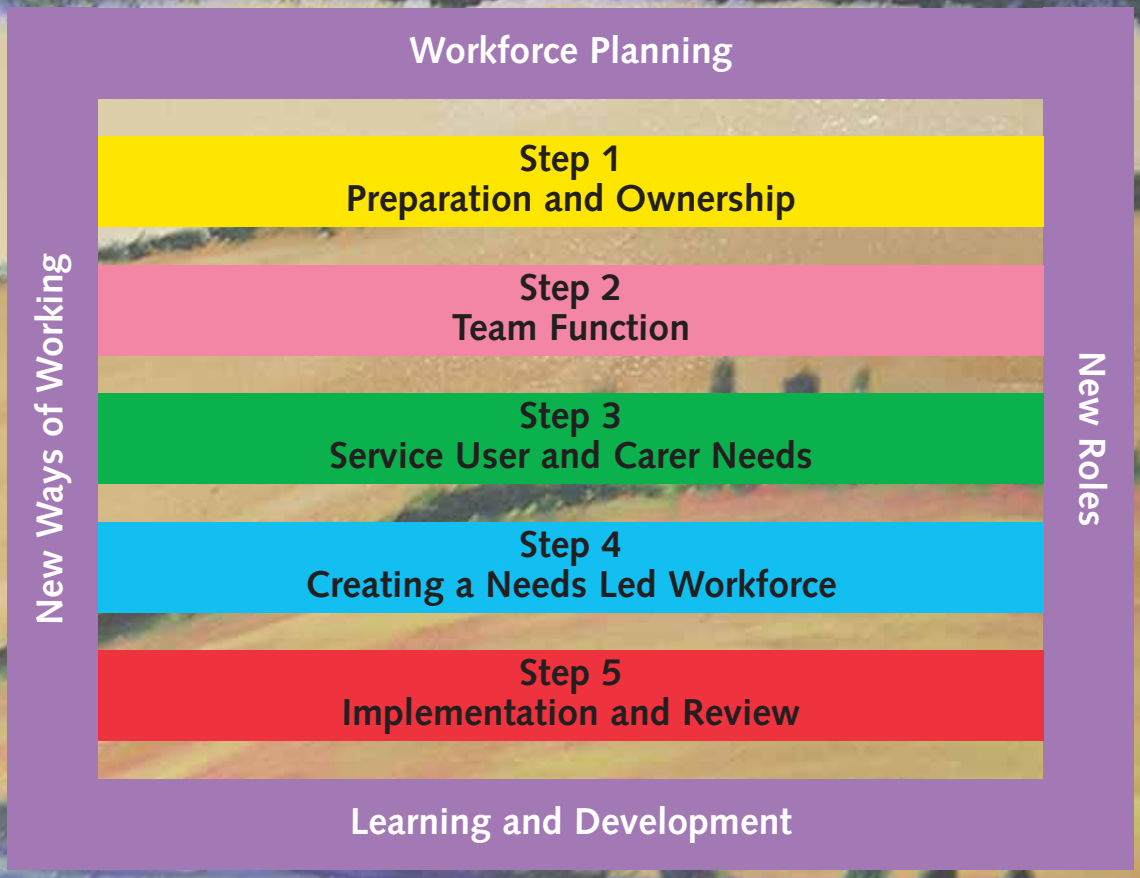
NWW New Ways of Working in Mental Health

Creating Capable Teams Approach (CCTA)

Best practice guidance to support the implementation of New Ways of Working (NWW) and New Roles



Participant's Handbook*

*To be read in conjunction with The Executive Summary

DH Department of Health

Creating Capable Teams Approach (CCTA)

Best practice guidance to support the implementation of New Ways of Working (NWW) and New Roles

Participant's Handbook

April 2007

DH INFORMATION READER BOX

Policy **HR/Workforce** Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document Purpose	Best Practice Guidance
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Title	Creating Capable Teams Approach
Author	DH
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Target Audience	Medical Directors, Directors of Nursing, Directors of HR, Allied Health Professionals
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Description	The CCTA is intended to help local health and social care services at a multidisciplinary team level to review their skills mix and refine their learning and development needs on the basis of service user and carer need.
Cross Reference	Mental Health: New Ways of Working for everyone
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Action Required	N/A
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Preparation Stage

Step 1: Preparation and Ownership

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Step 1: Preparation and Ownership

Aims

The Aims of Step 1 are to:

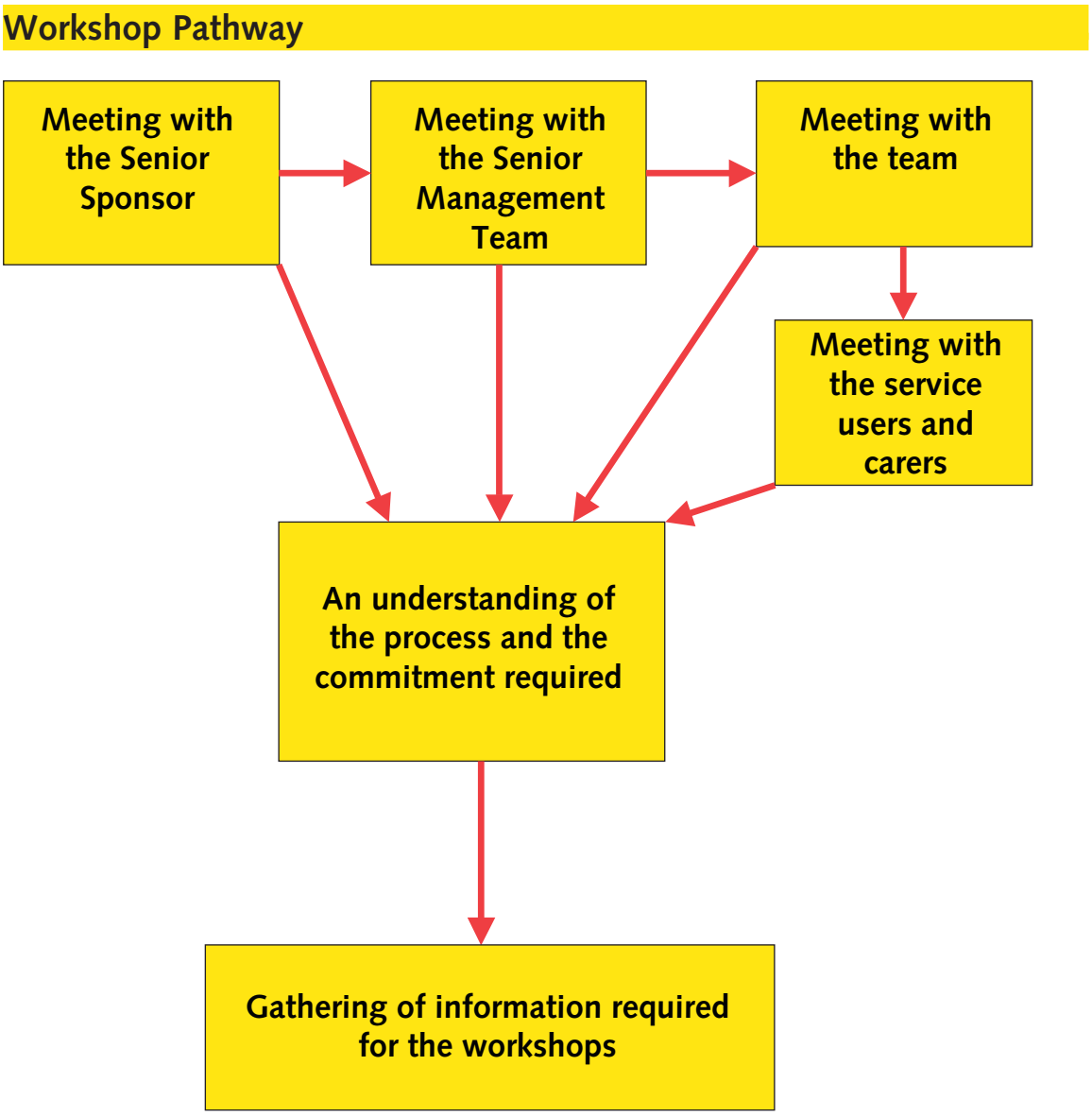
- Secure SMT commitment and approval
- Ensure all involved have an understanding of the National MH Workforce Programme (NMHWP) specifically in relation to New Ways of Working and New Roles, and where the CCTA fits
- Ensure all involved have a clear understanding about the CCTA process, implications, benefits and possible outcomes
- Ensure that the process is implemented efficiently and effectively
- Secure any resources required for the process
- Agree a funding envelope
- Gather the information necessary to support delivery of the CCTA
- Have an introduction to, and gain an understanding of, the 10 ESCs
- Begin to consider ways of working differently

To achieve the aims of this step, it will be necessary to have a number of preparatory meetings which, where possible, should take place within existing meetings. Consideration should be given to lengthening existing meetings to allow for adequate discussion about the CCTA.

The duration and number of meetings will differ within each organisation. However, it is crucial that an adequate amount of time is dedicated to Step 1 as effective communication and the commitment of all involved is essential to the success of the CCTA.

NB: It is essential that Step 1 is undertaken thoroughly prior to commencing Step 2. The team leader is responsible (2:4 Executive Summary) for ensuring that the team has undertaken all the preparation required, gathered the necessary information, and for signing off the process.

Step 1: Preparation and Ownership



Meeting the Senior Sponsor

Initially the senior sponsor and the instigator of the CCTA should meet to:

- Discuss key aspects of NWW and New Roles
- Discuss the CCTA process, implications, constraints and benefits
- Identify the proposed team and reason for selection
- Identify a potential facilitator and co-facilitator
- Agree the process of engaging the SMT
- Identify desired priority outcomes
- Agree service user and carer participation*
- Agree any necessary parameters and timescale
- Discuss any anxieties, concerns and queries relating to the process

Consideration should be given to setting up or using an existing meeting as a project group. The group could include heads of services/departments/teams and would have a clear understanding of the process which would enable them to provide support to the team and across all professions. This may also **help negotiate backfill** arrangements as one team could provide cover for another which could then be reciprocated.

It is also important that the senior sponsor maintains close contact with the facilitator and as a minimum attends the initial meeting with the team (Step 1) and the end of Step 4 to hear the plan of action.

***For further information and advice please refer to the service user and carer involvement handout.**

Meeting the Senior Management Team (SMT)

Prior to commencing the process, it is imperative that the organisation's SMT are fully supportive of the process. This can be achieved with support from the senior sponsor, by attendance at the SMT regular meeting to:

- Present an introduction to the CCTA
- Present the SMT briefing paper
- Discuss the implications, benefits and outcomes for the organisation
- Identify any organisational constraints that might impact on the project

- Establish effective communication and reporting mechanisms
- Identify any resource implications and authorise as necessary
- Clarify what financial resources may be available to support the implementation of change
- Ensure that the required information will be available
- Secure Senior Management commitment to and approval for the CCTA
- Agree any necessary parameters and timescale

NB: It is essential that the SMT are committed to the implementation of NWW and New Roles and that this message is conveyed to the team (1.4 Executive Summary).

Meeting the Team

Ideally to encourage ownership of the process the team should be presented with the information about the CCTA and be given the **choice** to decide if they wish to participate in the process. It is only natural for the team to have a number of questions and anxieties about the process so it may be necessary for a number of meetings to take place between the facilitator and the team. It may also be necessary for the team leader to have separate meetings/focus groups for certain members of the team to discuss their particular contribution to the process e.g. administrative staff, volunteers, service users and carers.

It is important that at the initial meeting with the team a discussion takes place to determine and agree, for the purposes of the CCTA, who the team consists of. As suggested in the executive summary the team should be multidisciplinary and may vary in size but should include service users and carers and those who contribute to the delivery of care.

The senior sponsor should also be present at one of the meetings to convey the organisation's commitment to NWW and New Roles. Where possible this process should be done at existing team meetings with the aims being to:

- Present an introduction to CCTA
- Ensure that the team understands the CCTA and what's in it for them
- Go through the facilitator's and participant's handbook to clarify the expectations and outcomes for each step
- Facilitate a discussion regarding their expected contribution, the process, implications, benefits and possible outcomes for the team
- Explore and identify any constraints/barriers that might impact on the project

- Agree service user and carer participation*
- Establish effective communication mechanisms
- Agree timescale and dates, times and venues for Steps 2, 3 and 4
- Present and discuss the reasons behind team selection
- Identify members of the team who will ensure the integration and support of services users and carers throughout the process
- Introduce team members to Module 2 of the 10 ESCs (see page 12)
- Discuss with team the completion of the individual diary sheets (see page 13)
- Provide all team members with CCTA participant's folders
- Ensure **that all** team members are aware that they will be required to participate throughout the process; this will involve supporting the team leader to gather the necessary information, recording information and feeding back to the whole group and completing some work outside of the workshops
- If some team members are absent from the meeting it will be necessary to identify and keep a record of other members of the team who will act as **buddies** and take responsibility for ensuring all information, including handouts is fed back to absent colleagues. This information should be recorded on the **buddy record handout**

***Team members may have some concerns about involving service users and carers in the process e.g. confidentiality, wanting to get your own house in order, not feeling able to speak openly etc. It may therefore be beneficial to arrange a number of meetings or focus groups to address this. If this remains an issue consider organising a workshop in relation to service user and carer involvement. It may also be helpful to explore with the team what the service users' and carers' involvement would look like in each step as some of the anxiety may be around not knowing what the process entails. For further information and advice please refer to the service user and carer involvement handout.**

Meeting with service users and carers

Service users and carers will need to be given all the relevant information about the CCTA to enable them to make an **informed choice** about if and how they want to be involved in the process. Ideally service users and carers should be involved in the whole process. However if, after receiving information about the individual steps, they do not feel it would be beneficial, or are unable to attend all three workshops, **Step 3 is the workshop that**

should take priority as it is at this workshop that the service user and carer needs are identified.

The CCTA process should involve a minimum of **two service users** and **two carers**, who ideally, should be those who use the services of the team. However, although some service users and carers may be willing to be involved in the process with their team, others may not. If this is the case, consideration should be given to approaching local service user and carer groups who would be willing to participate, or service users from other teams who would be happy to be involved in the process but not with the team that provides their care.

If the service users and carers are not from the team it may be necessary to arrange for them to meet with some of the team's service users and carers prior to the process to ensure they have a good understanding of any relevant issues.

It may be necessary for the team leader and facilitator to have a number of meetings with the service users and carers, separate to the team. The aims of these meetings would be to:

- Identify the benefits of their involvement from both an individual and service users and carer perspective and for the team and the organisation
- Present an introduction to the CCTA and provide handouts
- Go though each step and explore what their role would be
- Ensure they have a understanding of the CCTA and what their involvement before, during and after the process would be
- To address issues of support prior to, during and after the process
- To clarify issues relating to reimbursement for time, travel etc
- To explore any anxieties and concerns about the process
- To discuss respite etc arrangements for carers

NB: It is extremely important that service users and carers feel confident and have the skills to contribute and challenge in a workshop environment. It may also be necessary to arrange for an identified individual to support them during the process and to ensure the availability of supervision or debriefing after the workshops. For further information and advice please refer to the service user and carer involvement handout.

Preparation for Step 2

Prior to commencing Step 2 the team should undertake the following:

Information gathering

To inform and underpin the CCTA, it is necessary to gather a range of information which is essential to the delivery of Step 2.

Whilst some of the information required can be provided by the team, other data will be held by internal or external departments/services, particularly the voluntary sector who hold a wealth of information about the local community.

The senior sponsor and SMT should support the collection of the material required for this step by authorising access, and signposting the facilitator and team members to the appropriate resource.

It is ultimately the responsibility of the team leader to ensure all the relevant information is gathered prior to Step 2 however it is the role of the whole team to contribute to the collection and collation of this information.

Preparatory reading

All team members should ensure they read the following handouts prior to Step 3:

4) Service user and carer involvement
5) National Workforce Programme
6) New Ways of Working
7) New Roles
8) Diary of a NWW Consultant Psychiatrist

10 Essential Shared Capabilities (ESCs)

The 10 ESCs learning materials have been developed as a resource to inform practice, and support the delivery of **mental health and social care services** in England. The focus of the 10 ESCs is on attitudes, behaviours, expectations, and relationships that should be demonstrated, or evident, in the way services are planned and delivered and reflect how people who use mental health services, and those who support them, want and expect to be treated.

The 10 ESCs underpin the CCTA and are intended for **all staff** working within mental health services. It is therefore important that all team members participating in the CCTA have an understanding of the 10 ESCs. To support this process is it recommended that as

a **minimum** all team members complete module 2 of the 10 ESCs prior to commencing Step 2. Module 2 provides an introduction to the 10 ESCs and how they relate to key areas in mental health work and can be electronically accessed via: http://www.lincoln.ac.uk/ccawi/esc/esc_web/assets/index01.html

NB: It is recommended that the 10 ESCs are undertaken as a group activity however this does not need to be with the whole team but could be done with 4 or 5 team members, which should of course include service users and carers.

Diary Sheet

The diary sheet has been developed to support members of the team to begin to consider their current ways of working and how they may work differently in the future. The aim of this exercise is not to monitor time spent but to support individuals to begin to identify the tasks and activities they currently undertake and consider if they could be undertaken more appropriately/effectively by someone else.

It is recommended that the diary sheet be completed for 2 different days during 2 different weeks to ensure a broad representation of the work undertaken. The information provided on the diary sheet will be used throughout the workshops so it is important that participants keep their completed diary sheets in their CCTA folder and bring to all the sessions.

For further information about the use of a diary tool developed specifically to explore alternative ways of working for consultant psychiatrists see *New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts* (DH 2005).

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 1

CCTA TIMETABLE

STEP	DATE	TIME	VENUE
STEP 1 – Pre-workshops PREPARATION AND OWNERSHIP			
• Meeting/s with senior sponsor			
• Meeting/s with SMT			
• Meeting/s with team			
• Meeting/s with service users			
STEP 2- Workshop 1 TEAM FUNCTION			
STEP 3 – Workshop 2 SERVICE USER AND CARER NEEDS			
STEP 4 – Workshop 3 CREATING A NEEDS LED WORKFORCE			
STEP 5 – Post Workshops IMPLEMENTATION AND REVIEW			

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 2

BUDDY RECORD

If a team member is unable to be present at a meeting/workshop a buddy should be identified and their name recorded. It will be the buddy's responsibility to ensure all information, including handouts, is fed back to the absent team member. This information should be recorded below.

Absent team member	Buddy

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 3

INFORMATION CHECKLIST

Information required prior to commencement of STEP 2	By whom	From where	By when	✓
Data about the team – • Team establishment • Current number of staff • Number of vacancies	Team Leader	HR/Payroll		
Local demographic information relating to the team's locality which should include: • Population size • Age profile • Male/female mix • Ethnicity profile • Employment status • Geography • Any local intelligence/trends	Senior Sponsor	Public Health SHA Local Councils Workforce planning department Voluntary Sector Local strategic partnership and community plan		
The stated values of the organisation	Senior Sponsor			
Results of latest service user survey	Senior Sponsor	CEO		
Organisation's complaints data from the previous 6 months	Senior Sponsor	PALS		
Team operational policy and values (ensure all team members have a knowledge of)	The Team			
National policy implementation guidance (with key implications identified)	The Team			
Handout with agreed dates, times and venues for CCTA	Facilitator			
Service level agreements relating to the team (if applicable)	Senior Sponsor			
Information about NWW and New Roles already in existence within organisation	The Team	Workforce modernisation		
Current information about the national, regional and local NWW programme	Facilitator	NIMHE RDC workforce lead		

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 4

SERVICE USER AND CARER INVOLVEMENT

Section 11 of the Health and Social Care Act places a duty on all NHS organisations to make arrangements to involve and consult patients and members of the public in the planning, development and delivery of services. This includes people who use mental health services and their carers.

Why involve service users and carers?

- Service users and carers should have the right to be involved in decisions that affect their lives
- Involving service users means they are more likely to feel in control of their lives and this will enhance their self-confidence
- Service users and carers have a lot to contribute through their experience of a particular disability, illness or care services, that may not be available from any other source
- The contribution of service users and carers is unique because they tell it from their own viewpoint expressing their fears, joys and feelings which contributes to a better understanding for us all
- Effective involvement leads to:
  - More choice about the services provided
  - More effective partnerships of care between service users, carers and professionals
  - Better understanding of the effects of disability or illness on service users and their families
  - Better services based on identified needs
  - Better working relationships between service users, carers and staff
  - A critical insight into the effectiveness of particular interventions
  - Service users and carers feeling empowered, confident and valued; thereby making them feel more in control and so enhancing the quality of their lives

How to involve service users and carers in the CCTA

Ideally, the service users and carers involved in the CCTA should be those who use the services of the team. However, although some service users and carers may be willing to be involved in the process with their team, others may not. If this is the case, consideration should be given to approaching local service user and carer groups who would be willing to participate, or service users from other teams who would be happy to be involved in the process but not with the team that provides their care.

Service users and carers will need to be fully informed about the CCTA process and their role within it so they can make an **informed choice** about whether or not they wish to be involved.

Ask members of the team if they have any service users and carers, with whom they are currently working, or have worked with in the past, who may wish to be involved.

Arrange to meet with any interested service users and carers to explain the process, what it would entail and what's in it for them.

Contact the organisation's service user and carer lead to see if they are aware of anyone who would be interested in being involved.

If the service users and carers are not from the team it may be necessary to arrange for them to meet with some of the team's service users and carers prior to the process to ensure they have a good understanding of any relevant issues.

NB: It is acknowledged that some staff teams may be anxious about involving service users and carers in the CCTA process feeling that "they cannot speak freely" in front of service users or they "want to get their own house in order" first. However if service users are not involved it will defeat the object of the CCTA. For example, Step 3 requires identification of service user and carer needs. Without service user and carer involvement, the needs identified will be those perceived by the staff group, and therefore will not result in the development of a needs led, person centred service!

How to involve service users and carers in your organisation

- Ask past or present service users and carers if they wish to become involved (by letter or word of mouth)
- Advertise via posters, handouts, local newspapers, press, and local radio/TV
- Contact existing local groups, patient councils, projects, drop-in centres, day centres or forums
- Contact local or national voluntary groups
- Use of local "champions"
- Peer recruitment
- Advertise at local and regional conferences, workshops or any mental health activity
- Seek support from the CSIP Development Centres and Service Improvement Leads
- Seek support from Patient Advice and Liaison Service (PALS)
- Hold local events e.g. coffee mornings, parties, galas, meals
- Encourage people to become involved by providing a variety of opportunities for involvement where service users and carers can input at their level in a secure and comfortable way i.e. not just attending meetings e.g. writing booklets, pamphlets

How to gain the views of service users and carers

- Questionnaires
  - Exit questionnaires
  - "Thirty second" smiley faced satisfaction questionnaires
  - Reflective questionnaires
  - Traditional questionnaires
- One to one open interviews
- One to one semi-structured interviews
- Focus groups
- Patient/Carer forums and "self-help" groups
- Post boxes
- Postal surveys
- Telephone lines
- Open letters
- "Local Voice" meetings
- Consensus conferences
- User-led monitoring of services
- Web sites
- Photographic statements
- Patient diaries
- Through observation
- Patient tracking
- Via voluntary sector groups
- Via user-led (or involvement in) research projects
- PALS

NB: Whilst these are some suggestions about WHY and HOW to involve service users and carers consideration must also be given to providing support, encouragement and training to enable service users and carers to fully utilise their skills and expertise and achieve their full potential e.g. public speaking, committee and meeting skills, IT skills, time management, work-load management etc.

Good practice when involving service users

- Ensure that plenty of notice is given and that service users and carers are fully aware of what the activity will entail
- Ideally a minimum of 2 services users and 2 carers should be involved
- Arrange a pre-meet prior to any formal work
- Ensure the briefing and debriefing takes place
- Do not use jargon
- Ensure adequate breaks and refreshments
- Ensure appropriate facilitation to encourage and support active, relevant and meaningful participation
- Continuously question how the experience of involvement can be improved
- Ensure adequate support for service users prior to, during and following the activity
- Ensure basic ground rules are set based on mutual respect
- Check if service users/carers have any special needs or disabilities and that aids and adaptations are available if required
- Ensure appropriate reimbursement arrangements are in place i.e. travel, time
- Consider service users' and carers' needs and be flexible when arranging the time and venue of the activity

For further information:

- Carers UK 020 7490 8818 www.carersuk.org.uk
- Mental Health Foundation www.mentalhealth.org.uk
- Mind www.mind.org.uk
- Rethink www.rethink.org
- Sane line www.sane.org.uk

- MOSOS, Service user monitoring team www.mosos.org.uk
- Together – working for well being www.pavpub.com
- Department of Health (2003) *Strengthening accountability – Involving Patients and the Public, Policy Guidance*, Section 11 of the Health and Social Care Act 2001 London DH http://www.dh.gov.uk/assetRoot/04/03/53/87/04035387.pdf
- Department of Health (2003) *Strengthening accountability – Involving Patients and the Public, Practice Guidance*, Section 11 of the Health and Social Care Act 2001 London DH http://www.dh.gov.uk/assetRoot/04/07/42/92/04074292.pdf

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 5

NATIONAL MH WORKFORCE PROGRAMME (NMHWP)

Working primarily at the national level, the purpose of the NMHWP is to support local workforce change through the publication of guidance and practical support that can enable greater flexibility for making change. Guidance is developed through collaborative work with professional bodies and other national workforce players and implementation is supported through various local pilots and accelerated development programmes. Such development is for the whole of the mental health workforce. This includes all staff, professionally qualified or not, across the full age range of mental health services (children, people of working age, and older people) and across all NHS and social care commissioners and providers of mental health.

The NWP is supported by a workforce lead in each of the eight CSIP/NIMHE Development Centres across England. The NMHWP also works very closely with other key stakeholders. These include Skills for Health; Skills for Care; the Centre for Clinical Academic Workforce Innovation; the Department of Health; the Workforce Review Team; Strategic Health Authorities; the Mental Health in Higher Education network; the various Royal Colleges; members of the voluntary and independent sector; and service users and carers.

The introduction of NWW and New Roles is about recognising, that with rising expectations and demands, more of the same is not practical anymore. The workforce needs to be more flexible, and if we are to increase staff numbers we need to also create opportunities such as new roles. To attract people with different skills or aspirations into the Mental Health Workforce, the NMHWP is helping to do this at a national level within a workforce development framework.

National Mental Health Workforce Strategy

In August 2004, the NMHWP published a National Mental Health Workforce Strategy that sets out six key aims to:

- Improve **workforce design and planning** so as to root it in local service planning and delivery
- Identify and use creative means to **recruit and retain people** in the workforce
- Facilitate **New Ways of Working** across professional boundaries
- Create **New Roles** to tap into a new recruitment pool and so complement existing staff types
- Develop the workforce through revised **education and training** at both pre- and post-qualification levels
- Develop **leadership** and **change management** skills

Key contact

Roslyn Hope, Director of the NWP, West Midlands CSIP/NIMHE Development Centre. (Roslyn.hope@csip.org.uk)

Keep in touch

The NWP produces a newsletter **"Workforce"** which provides up to date information about the elements of the Programme. If you would like to request a copy please contact john.allcock@dh.gsi.gov.uk providing your full name, job title and full postal address (including post code).

Key Publications

Listed below, are the Key Publications produced or commissioned by the NWP in conjunction with the Department of Health and other key stakeholders:

- Primary Care Graduate and Gateway workers (January 2003)
- Guidance on Support, Time and Recovery workers (March 2003)
- Guidance on Workforce Design and Development (March 2003)
- Report on Work Based Learning (March 2003)
- "Workforce" newsletters (June 2003; September 2003; January 2004; July 2004; November 2004; April 2005; and December 2005)
- National Continuous Quality Improvement Tool (July 2003)
- National Occupational Standards for Mental Health (August 2003)
- Stigma of working in mental health services (October 2003)
- The Clinical Activities of Mental Health Lecturers in Higher Education Institutions (November 2003)
- Joint DH/Royal College of Psychiatrists Recruitment and Retention Action Plan (March 2004)
- Education and Training – Guidance for Acute In-patient staff (June 2004)
- Organising and Delivering Psychological Therapies (July 2004)
- Mental Health Workforce Strategy (August 2004)
- New Ways of Working for Psychiatrists – Interim Report (August 2004)
- The Ten Essential Shared Capabilities (August 2004)
- Community Development Workers – Interim Report (December 2004)
- Mental Health Workforce Recruitment and Retention Research Project (January 2005)

- Community Development Workers – Education and Training Supplement (October 2005)
- New Ways of Working for Psychiatrists – Final Report (October 2005)
- Joint Guidance on the Employment of Consultant Psychiatrists (October 2005)
- Discussion paper about "The social work contribution to mental health services – The future direction" (November 2005)
- Recruitment and retention of mental health nurses: Good Practice Guide (April 2006)
- Report on the NIMHE National Workforce Planning Pilot Programme (June 2006)
- DVD – New ways of working in psychiatry (Summer 2006)
- Recovery Approach Learning materials (September 2006)
- Community development workers – final handbook (November 2006)
- Learning and Development Toolkit (April 2007)
- Mental Health: New Ways of Working for Everyone (April 2007)
- Creating Capable Teams Toolkit (April 2007)

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 6

NEW WAYS OF WORKING

Mental health care has become more diverse and flexible and more of the same is not sustainable and no longer meets the needs of service users and carers. In 2003 NIMHE/CSIP began a major programme of work in partnership with the national professional bodies. The programme aims to engage all professionals in addressing New Ways of Working, to ensure the right people, with the right skills are in the right places, thus making the best use of existing skills and experience and freeing up highly skilled staff from routine work whilst also creating new opportunities to bring different people and skills in to the workforce.

The work, although initially focused on the role of the psychiatrist, now encompasses all mental health professionals and practitioners.

NWW for Social Work

The aim of this programme is to raise the profile of the future contribution of social workers. In 2005, a Discussion Paper focusing on the social work contribution to mental health care was distributed, followed by regional and local events to formulate responses. The responses were recorded in a Report produced in March 2006 and in April 2006, a national conference was held to discuss the next steps.

In May 2006 a NWW sub-group convened and a programme of work commenced primarily looking at 4 Key Areas around:

- Leadership
- Social work research
- Career progression/pathway
- Social work identity

The aim is to produce a set of recommendations, illustrating a number of examples of good practice, and clarifying next steps beyond March 2007.

NWW for Psychiatrists

The NWW for Psychiatrists sub-group has been meeting for over 2 years. The group, which has a good multidisciplinary representation and strong service user participation, initially concentrated on defining the distinctive contribution of the psychiatrist, and in developing models, often using pilot projects, for New Ways of Working for consultant psychiatrists.

The group has now broadened its remit to look at NWW for all psychiatrists, and the different specialities within psychiatry. It has contributed to the development of new joint guidance on the employment of consultants, and via the link with the Royal College, to the development of a Medical Directors' network. Members of the group have facilitated workshops on NWW at Trusts around the country. The group is

now examining key themes for further work which can be carried out across the professional groups, including leadership and team working, and NWW in medicines management, as well as undertaking more focused work in collaboration with others on complexity.

NWW for Psychologists

Applied Psychologists include clinical, counselling, health and occupational psychologists; there are specialties, in particular, within clinical psychology. The NWW for Applied Psychologists Group has been meeting for a year and is focusing on 7 streams of work which are:

- Education and Training (largely focusing on professional training and the need for change)
- New Roles, including Psychology Associate (pilot in NE), Graduate Workers, Psychology Assistants
- Organisation of the Delivery of Psychological Services (how psychologists could and should work in organisations)
- Career framework and Leadership
- Team working (the role of the psychologist as a team player, promoting effective teams)
- Improving Access to Psychological Therapy (the psychologist's contribution)
- Mental Health Legislation – future involvement for psychologists.

There was a national stakeholder event in July 2006 to share the work so far not only with other psychologists but also with other professions, managers and commissioners.

Papers can be found on the British Psychological Society website at: http://www.bps.org.uk/dcp/dcpfaqs/psychologyassociateroles.cfm

NWW for Nursing

The 2006 Chief Nursing Officer's Review of Mental Health Nursing *From values to action* provided good practice guidance for the future development of the profession across England in relation to practice, educational and organisational issues. New Ways of Working was an underlying theme and the review highlighted a number of areas in which the development of New Ways of Working was important.

A group is now being established, membership of which will include service user and carer representation, the nursing profession itself (including representatives from clinical, managerial and academic backgrounds and from staff organisations) and other occupational groups in mental health.

The group will build on the work already being carried out in response to the Review recommendations and a number of themes will be identified for further work. These are likely to include:

- The implementation of nurse prescribing

- The development of positive alternatives to traditional junior doctor roles.

The work of this group will form part of the work programme overseen by the National Steering Group on New Ways of Working in Mental Health and will be undertaken by the NIMHE National Workforce Programme in partnership with the Nursing Profession.

NWW for Allied Health Professions

The Mental Health AHP Advisory Group (MHAHPAG) is leading the work on NWW for AHPs, reporting to the NWW National Steering Group.

Four key themes relating to NWW for AHPs have been identified and each of these will be explored and developed by a project group. These are:

- Education and Training
- New Roles
- White Paper
- Team-working

There is some overlap in the issues identified for each group – for example Continuing Professional Development is relevant to both Education and Training and New Roles.

It is also recognised that there are already key work-streams in progress for many of the issues. For example the competence-based AHP career framework and improving access to psychological therapies are relevant to all four project groups. It is not intended to duplicate work already on-going, but it is an opportunity to link the strands together, building on the report NWW for psychiatrists and the work being undertaken for NWW for psychologists, particularly in relation to team-working.

The four project groups each have two co-chairs and are currently establishing group membership including AHP professional bodies, other professions and service users as well. There will also be opportunities for a wide range of contributors to 'have their say' in these project groups through a 'virtual e-mail group'.

NWW for Pharmacists

Medicines management (MM) and secondary care pharmacy services in mental health have for many years been poorly funded and largely ignored. However, since 2000 there has been a far greater focus on both MM and pharmacy services throughout healthcare and this has highlighted both the paucity of pharmacy resource available to many Mental Health Trusts (MHTs) to both support MM and medicine related New Ways of Working (NWW) and the potential impact that pharmacy staff can have both on the clinical use of medicines and the roles of other clinical staff.

Between 2000 and 2005 the Changing Workforce Programme (mental health) supported 3 phases of initiatives to provide MHT pharmacy departments with the opportunity to develop small projects that demonstrated improvements to patient care through NWW or impact on other MHT staff by NWW of pharmacy staff. The aim of the 'Spread Programme' was to make best use of pharmacists' skills in psychiatry and improved ways in which pharmacological treatments were used.

The work of the pharmacy group is now focused in 3 areas:

- The publication and dissemination of the findings of the Spread Programme
- The review of secondary care mental health pharmacy manpower
- The development, consultation and publication of a NWW for pharmacy in mental health document

NWW in Primary Care

The NWW in primary care (PC) sub-group consists of members from across the primary care team, social work, people with experience of using mental health services and their carers, mental health professionals and representatives from the Royal Colleges and other professional organisations.

The Aims of the sub-group are to:

- Champion New Ways of Working in primary care mental health, and promote a positive message about the benefits to service users and carers.
- Work within a multidisciplinary and multi-agency context, recognising that no single professional group can be considered in, or work in, isolation.
- Seek ways to mainstream New Ways of Working in mental health, so that 'new ways' become the accepted and expected ways of working both within the field and by the wider public.

The outputs should include:

- A Primary Care section in the final *New Ways of Working in Mental Health* report (March 2007).
- Examples of innovative practice on meeting MH needs in PC, in collaboration with secondary care and including CMHT reconfiguration.
- Addressing the practical issues of liaison/interface work: e.g. description of the Clinical Responsibilities – medical, practitioner and prescribing – across the interface.
- An appendix to the Primary care section giving guidance for scenarios such as:
  - GPs asking for telephone advice
  - GPs sharing care with MH professionals for people with more stable psychosis
  - GPs providing care for people with stable psychosis

  - Linked specialist mental health workers doing brief assessments in primary care (but still employed by specialist trusts)

- The development of an evaluation framework to help inform PC and PC commissioners understand and consider NWW.
- A description of the future direction of travel.

NWW and the implications for Acute In-patient Care

Workforce in general and NWW in particular are currently being addressed as part of the Acute In-patient Programme, in collaboration with the NIMHE National Workforce Programme.

There are three key areas of work:

1. Skill mix in in-patient settings – identifying positive practice to inform future guidance (this will not be prescriptive as it will depend on local starting points and needs)

2. The role of the psychiatrist in the in-patient setting, both as lead consultant and as an individual clinician (this will link with NWW for psychiatrist work and a separate survey is about to take place in sites already working with the Healthcare Commission)

3. The role of the ward manager/clinical nurse lead (to address the career pathways for nurses in IP settings)

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 7

NEW ROLES

In 2003 NIMHE/CSIP began a major programme of work in partnership with the national professional bodies. One of the aims was to support the introduction of New Roles to meet the needs of service users and carers.

Some of the New Roles were linked to national targets and supported by national policy implementation guidance whilst others were introduced with the support of Workforce Development Confederations in response to local/regional needs.

Support, Time and Recovery (STR) Worker (Foundation, Intermediate, and Senior)

The STR Worker is a service-user defined role that evolved from the work of the Workforce Action Team (DH 2001). Policy Implementation Guidance was published in 2003.

The STR Worker:

- Provides **support**, gives **time** and helps aids the **recovery** of a service user
- Has a value base of recovery and social inclusion, and so enables individual service users to attain a lifestyle which they realistically aspire to
- Is led by the needs of the service user
- Works with individual service users and supports the care planning process
- Works at the interface between community and in-patient services
- Supports the service user's self-management of health, access to employment/volunteering opportunities, education, leisure and other mainstream resources
- Works as part of a team
- Has a defined education and training pathway and structured supervision framework

STR Workers can be employed in the Health, Local Authority, Social Services or the non-statutory sector and are required to undertake training ranging to NVQ level 3, depending on the requirements and responsibilities of the role.

For further information see:
Department of Health (March 2003) *Mental Health Policy Implementation Guidance – Support Time and Recovery (STR) Workers* – DH London http://www.dh.gov.uk/assetRoot/04/01/94/56/04019456.pdf

For information about the national introduction of STR workers see:
http://www.wise.nhs.uk/sites/accelerated_development/default.aspx

Community Development Workers (CDW) – for Black and Minority Ethnic (BME) communities

The CDW is a non-clinical role with strategic responsibility. The role is pivotal to the effective delivery of DRE – *Delivering Race Equality in Mental Health Care* (DH 2005) – a five-year action plan for tackling discrimination in the NHS and local authority mental health services. Interim Policy Implementation Guidance for CDWs was published in December 2004 (DH 2004).

The CDW role has four key components: **Change Agent, Service Developer, Access Facilitator and Capacity Builder.**

The CDW:

- acts as a link – bridge builder – between local BME communities and health and social care providers
- promotes greater understanding and ownership of the issues facing people from those BME communities, regarding their access to, and experience of, local mental health services
- informs, and contributes to, the commissioning and provision of better, more responsive services

CDWs can be employed by PCTs, by Trust providers of specialist mental health services, by local authorities or non-statutory organisations. The methods by which they engage with the community will be determined locally, according to need. The support and supervision arrangements for each CDW will need careful consideration. CDWs are expected to undertake training and education for the role: the *Education and Training Supplementary Policy Implementation Guidance for CDWs* (DH 2005) provides a detailed framework to assist localities in their commissioning and provision of appropriate education and training programmes for their CDWs.

For further information see:
Department of Health (Dec 2004) *Mental Health Policy Implementation Guidance – Community Development Workers (CDWs) for Black and Minority Ethnic Communities – Interim Guidance*
DH London
http://www.dh.gov.uk/assetRoot/04/10/09/33/04100933.pdf

Ward Housekeepers

The ward housekeeper is a non-clinical role that works as part of the ward team. The key responsibilities are cleanliness, catering and the ward environment therefore freeing nurses up to spend more time on clinical care.

The ward housekeeping service is based on 11 service standards, developed in conjunction with patients.

- Maintenance of environment
- Cleanliness

- Equipment
- Catering
- Linen
- Control of infection
- Health and safety
- Supplies
- Privacy and dignity
- Customer care

A ward housekeeper may be employed by the trust or an external contractor or a PFI contractor, but remains **accountable to the ward manager** on a day-to-day basis.

Training for the Housekeeper role may involve NVQ Level 3 in Customer service.

For further information see:
NHS Estates (2001) *A first guide to modern and dependable housekeeping services in the NHS* HMSO Norwich
http://www.dh.gov.uk/assetRoot/04/11/66/91/04116691.pdf

Assistant Practitioners

The Assistant Practitioner role was initially developed across the Greater Manchester Strategic Health Authority area, as a response to local need, whilst also providing a career ladder for experienced health care assistants.

The role has since been widely adopted, supported by the NHS National Practitioner Programme. Assistant Practitioners provide direct or indirect care or treatment, and can work in a variety of services: mental health, acute hospital wards/departments, GP practices, maternity, children's, intermediate care, and A and E services.

The Assistant Practitioner, Mental Health

- Contributes to assessment and implementation of the care plan
- Undertakes therapeutic activities/interventions
- Supports social inclusion
- Once trained in phlebotomy, can assist in Clozaril clinics
- Works in either in-patient or community settings

The role requires working as a "trainee" while undertaking a 2 year work-based Foundation degree in Health and Social Care.

An assistant practitioner leaflet is available at
www.gmsha.nhs.uk/core/dtw/assistant_practitioner_leaflet.pdf

For further information see:
http://www.gmsha.nhs.uk/core/dtw/assistantorg.htm

Psychology Associates

The new Psychology Associate role is currently being developed and piloted by 5 trusts in the north east, in conjunction with Newcastle and Northumbria Universities. This role was suggested as part of the 'New Ways of Working for psychologists' to create a new grade in between the assistant's role and qualified clinical psychologists, which would be primarily concerned with offering therapeutic interventions in a specialist field.

The role requires completion of MSc Psychology in Health Care and once trained, the Associate will undertake interventions usually described by protocol. It is anticipated that the role will reduce psychology waiting times, and free up chartered psychologists to undertake activities more appropriate to their level of training and expertise.

The role was created to offer a career path which would offer training for experienced assistants to go on and practise as a scholar-practitioner and as an alternative career pathway to the doctorate course in Clinical Psychology.

The Psychology Associate:

- Assists in psychological assessment
- Assists with psychological interventions
- Undertakes audit and research, particularly in relation to service evaluation

Advanced Practitioners

The Advanced Practitioner is a generalist new role, not pre-determined or fixed by either a profession or previous post. The role is open to anyone from a health or social care regulated profession. It has been developed in order to address the continuing impact of changes to the medical profession, so that wider teams of professionals can undertake some of the duties currently undertaken by medical staff.

The Advanced Practitioner:

- Provides an advanced level of professional practice, knowledge and skills

- Is self-directed, manages risk, and is a member of a wider professional practice/service team
- Has own patient/client caseload, with decision-making responsibilities
- In many cases, manages medications, including assessment, review and prescribing
- In most cases, undertakes a physical examination, history taking, diagnosis, and treatment planning
- Refers to others, signposts patients to services, and co-ordinates care and treatment

Training involves completion of a work-based MSc in Advanced Practice (Health and Social Care).

Gateway Worker

The purpose of the gateway role is to strengthen access, and to provide community triage for people who may need urgent contact with specialist services. The role will support access to services in an emergency as well as ensuring smooth pathways between primary and secondary care.

Some examples of the role are:

- To support primary care to assess and triage complex cases in partnership with primary care liaison services
- Work in partnership with A and E and NHS Direct
- Provide training and support for primary care staff
- Provide a single point of access for people in crisis

For further information see:
Department of Health (October 2002) *Fast-Forwarding Primary Care Mental Health – Gateway Workers* DH London
http://www.dh.gov.uk/assetRoot/04/06/11/12/04061112.pdf

Graduate Primary Care MH Workers

GPCMHWs have been identified to be positioned in primary care settings to support the management and treatment of patients with common mental health problems across the lifespan; children to older adults.

The post holder is required to have a degree (2:2 or above) and the role is designed to enhance service provision and the development of mental health in primary care responding specifically to local needs and target populations within GP practices.

The 3 domains of the role are:

- Patient focused clinical role involving direct patient contact

- Practice development/Clinical governance
- Network liaison

For further information see:
Department of Health (Jan 2003) *Fast-Forwarding Primary Care Mental Health – Graduate Primary Care Mental Health workers* DH London
http://www.dh.gov.uk/assetRoot/04/06/11/12/04061112.pdf

Responsible Clinician (Mental Health Amended Bill)

The Responsible Clinician (RC) will replace the current role of Responsible Medical Officer (RMO).

The significance of this change is that, whereas the RMO role was restricted to medically trained and qualified mental health doctors, the RC is open to other **non-medical** senior clinicians. All RCs will have to be formally approved and undergo approved training.

The RC will be the lead clinician for all detained service users subject to the Act. Indeed, this role will provide the clinical lead for both formal and informal service users.

The RC role, whilst not engaged in the initial assessment process under the Act, which will continue to be undertaken by two specialist doctors and an AMHP, will have the power to assess service users subject to Section 3 with regard to renewals. They will also have a lead clinical role with regard to making the newly introduced Community Treatment Orders.

In all other aspects of service user care and treatment, they will have a similar role to that of the existing RMO, e.g. taking the final decisions regarding leave from hospital, and indeed discharge, although wherever possible this will be done collaboratively with the multidisciplinary team.

All RCs will be subject to satisfying specific competence criteria, an approval process, and a re-approval process after five years.

It is anticipated that existing RMOs will convert to RCs when the Act is introduced, but will only be approved for a period of three years.

For further information see:
www.dh.gov.uk/assetRoot/04/08/89/15/04088915.pdf

Mental Health Amended Bill – Approved Mental Health Professional (AMHP)

The AMHP will replace the existing Approved Social Worker (ASW).

The major significance of this change is that other **non social-work** mental health professionals (nursing, psychologists and occupational therapists) will be able to act in the role of the AMHP subject to training, qualification and formal approval and registration.

The duties and responsibilities of the AMHP will be almost identical to the ASW, although they will have new responsibilities with regard to Supervised Community Treatment and the amendments to the Nearest Relative.

Whilst the amended bill will provide the opportunity for Trusts/Local Authorities to employ staff other than ASWs in this role they do not have to use this power and can continue to employ social workers to undertake this role should they wish to do so.

For further information see:
www.dh.gov.uk/assetRoot/04/08/89/15/04088915.pdf

Locally developed roles

Some organisations have already begun to develop roles in response to local need, examples of which are given below:

Physical Care Practitioner

The Band 7 (AfC) Physical Care Practitioner role was developed in response to unmet, and partially met, physical care needs for in-patients in mental health services for older people.

Initially the post served the continuing care wards, but has expanded to provide a physical screening and assessment clinic to a day hospital. As well as undertaking 6-monthly routine physical examinations and assessments of patients the post holder responds to deterioration in patients' health. Training as an independent nurse prescriber has enabled the treatment of many physical health problems. The role also makes direct referrals to acute hospital departments (e.g. audiology) and arranges admission of patients where needed.

The post (initially funded for 12 months from the Strategic Change Fund) has enabled the reduction of the Service Level Agreement with local GPs who now provide out of hours cover only, and this in turn has enabled the funding of the post recurrently.

The post holder also leads on health promotion workstreams (e.g. smoking cessation, blood pressure management) and the Liverpool End of Life pathway. The post has been unanimously well received by Multidisciplinary Team (MDT) colleagues, patients and carers and it has contributed to improved quality of care and life for the most disabled patient group.

For further information contact: Sarah.McGeorge@cddps.nhs.uk

Associate/Assistant Practitioner

The Band 4 (AfC) associate/assistant practitioner roles were developed within a Behaviour service, originally to give some promotional structure for unregistered staff that had, through training and experience, developed their practice.

The assistant practitioners manage their own caseloads, providing assessment and treatment for people who have Learning Disabilities and present challenging behaviours, and work autonomously, only having assessment reports and treatment programmes ratified by Registered nurses prior to implementation.

The associate practitioners work in a similar way but in different areas. One is responsible for coordinating activities; this includes assessment of patients' structured activity and motivational assessments, and developing opportunities for people with challenging behaviours to have a more extensive range of structured daytime and social activities available to them.

An associate practitioner also works within an Autistic Spectrum Disorder (ASD) Project requested by the Learning and Skills Council to assess level of need for further education provision for people with an ASD in the County Durham area and also to facilitate training to college staff and tutors in the County Durham area.

For further information contact: kaye.wilson@cddps.nhs.uk

Associate Nutritional Practitioner

The Band 4 (AfC) associate nutritional practitioner role was developed in response, partly to unmet need and having limited provision for dietitians and Speech and Language Therapy Support (SALT), but also recognition nationally of malnourishment in patients during hospital in-patient episodes.

Food plays an essential part in all of our lives and to the recovery process, but there is increasing evidence to suggest it has an important role to play in our mental as well as physical health. The health of the workforce is important too, and people often make poor health choices for a variety of reasons. Health promotion and health education to encourage healthy living should be a key goal in health care if we are to break the cycle of malnourishment, obesity, coronary disease and other associated problems.

In older persons, provision of adequate diet and fluid intake is essential in health maintenance and recovery, but the means to achieve this are often compromised.

This is possibly the first role of this kind in England in the specialty of mental health and learning disabilities. The practitioners are responsible for ensuring that all patients receive a thorough nutritional assessment and monitoring throughout their stay in hospital, that food provision is available 24hrs and in a variety of means to ensure choices can be made and that staff see this as a priority. They screen referrals to dietitian and SALT services, implement and monitor food supplements and educate users, carers and staff on what a healthy, balanced diet should consist of, working within the means and lifestyle of the individual.

Once the role is established on the in-patient units, it will progress into day hospital, community and to nursing and residential homes to try and prevent unnecessary admission to hospital through malnourishment or associated problems.

For further information contact: Kevin.Stubbings@cddps.northy.nhs.uk

Employment and Education Opportunities Officer

Working with adults with severe and enduring mental health, drug and alcohol addictions the key task of this role is to enable and support substance misuse and mental health service users to achieve full-time or part-time paid or voluntary employment and/or obtain educational or training qualifications. This role also enables service users to retain, return to or obtain full-time work and/or access appropriate educational or training courses, as this is seen as a motivating factor for recovery.

The programme for each person is service user led. During this process service users are encouraged to access meaningful occupation by doing voluntary, paid or unpaid work, training or education with a long term aim for them to obtain full-time employment appropriate to their abilities and needs. Support to do this can be over several years, until the person has recovered sufficiently to return to full-time work.

The approaches used are not medical and could be applied to other vulnerable groups in society. All referrals come from the Community Mental Health Teams, the Drug and Alcohol Team and the local addictions service.

For further information contact: Jane.Beacher@nyypct.nhs.uk

Community Support Officer

Working with adults with severe and enduring mental health drug and alcohol addictions, the aim of the role is to ensure service users, and their immediate families, have adequate and suitable accommodation and that their **income is maximised**. The key tasks of the role are to:

- Advise and support individuals to enable them to access and/or retain suitable accommodation
- Ensure individuals are aware of their rights (with regard to housing, benefits, education and employment issues), obtain appropriate welfare benefits and housing and, where necessary, mediate and advocate on their behalf with the relevant agencies.

The outcome of the role is that it:

- reduces stressful situations for the service user by providing them with practical support and guidance so enabling them to concentrate more on recovery from their illness
- reduces instances of homelessness and debt
- ensures they obtain their full financial entitlement

- improves the service user's independence

The approaches used are not medical and could be applied to other vulnerable groups in society. All referrals come from the Community Mental Health Teams, the Drug and Alcohol Team and the local addictions service.

For further information contact: Jane.Beacher@nyypct.nhs.uk

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 8

DIARY OF A "NEW WAYS OF WORKING" CONSULTANT PSYCHIATRIST

Sunday 5th November 2006

Bonfire night tomorrow, although from the flashes and bangs I can hear and see through the bathroom window it appears to have arrived a day early. The dog doesn't appreciate the noise and is attempting to insert herself into the 3" space beneath one of the beds.

This is really quite a good time for reflection, as it is now a year since my job changed radically in line with the principles of News Ways of Working. Last year I began working in a completely different way, with a sense of trepidation and excitement, wondering whether this big experiment would be a gloriously exploding pyrotechnic display or a complete damp squib.

Things have certainly changed from the days when I would feel a knot of tension in my stomach on a Sunday evening as my attempts to block anxiety about what faced me the following day failed rapidly. I used to have a big caseload of about 300 patients that I prided myself on seeing as "regularly as possible". "Given how tremendously busy I was" I used to compare myself to my colleagues and we used to compete to see who could carry the largest burden of responsibility. I used to constantly look over my shoulder for fear that someone in the team would do something that reflected badly on me. After all I did have overall responsibility; whatever that meant!

It was quite a relief as the rich web of myth and inaccuracy surrounding my role and responsibility began to be unpicked. The ideas developed with the backing of the General Medical Council, the British Medical Association and the Royal College of Psychiatrists around personal and distributed clinical responsibility came to me as quite a relief. I remember sitting down with my team members and feeling a sense of comradeship as we discussed the implications within the team. As I pointed out to them, it was now clear to me that although I was personally responsible for the cases I was seeing, for the advice I gave to team members and had a leadership role within the team (part of which was to ensure the effectiveness and competence of its members), I did not have personal responsibility for whatever clinical actions they took. There was a collective sharp intake of breath as we discussed this but a sense over the following months of working together for a common aim started to develop. The long lines of worried Community Psychiatric Nurses (CPNs) standing outside my office began to dwindle away as a sense of confidence developed in the close-knit and increasingly well oiled workings of a more effective team.

They had quite a shock, and so did I, as caseloads began to transform! We set ourselves the surprisingly modest target of analysing just who was in the service, and were truly amazed by the results. We found people on caseloads who were long deceased but had never been removed from the system. We found people being seen because they were "nice" who we as clinicians enjoyed seeing, but who were really so well that they didn't even need to be managed in primary care. We found a whole host of people who had been ill (often very ill) who were now quite stable but were being seen every 2–3 months in my clinic for a bit of a chat and the monitoring of their physical symptoms and medication. I had to ask myself "did I personally

need to see them all the time". It was fairly easy to set up a team to support these individuals, many of whom over time have gradually moved back into primary care. Many are still seen and when they become unwell I can trust the CPN and Social Worker to know when they should be reviewed by me.

My caseload has fallen so dramatically that one of the CPNs was joking with me the other day; that my list is the shortest in the team. How things have changed!

As I lie here, reflecting, hoping not to drop this Dictaphone into the increasingly cooling waters of the bath I am aware that I am not anxious about going to work tomorrow. I don't expect to walk in and find a service anxiously waiting for me to turn up. I do expect to find a team with a sense of identity and common purpose increasingly proud of its effectiveness that sees me as a valued specialist member.

Monday 6th November 2006

Time to switch on the Blackberry and load the emails on to the system. I try to be disciplined and not read my correspondence over the weekend although some times I am tempted. I have found the electronic PDA… which doesn't stand for Pester Doctor Again as I was advised by a colleague, but Personal Digital Assistant or Blackberry, to be a useful tool, which helps me in working in a more modern way. It makes me accessible but less intrusively than by phone call. Team members know that they can email me at any time and I will respond. I can click over on to my electronic diary which my secretary coordinates and I know at all times what I have to do during the day. Trusting other people to coordinate my diary was a bit of a step for me but has proved extremely useful and effective. No more double bookings! Team members now know they can fit in people to see me and they know when time is available. They know that they can attach documents to my emails bringing me up to date quickly with any developments. Crucially they trust that I trust them to make those judgements.

The working week starts with a team meeting and this has become the centre of the working week. All communication comes to the team manager; all referrals enter through their structure, and, no, the GPs aren't jumping up and down! They were a little challenged a first but once they realised their patients would be seen effectively and efficiently by the most appropriate professional they were very happy. The team has become proud of its abilities and its developing skill base. We now have an advanced practitioner and two nurse practitioners within the team. They have been trained in supplementary and now independent prescribing and I have trained them in that mysterious skill of clinical formulation. I now work with colleagues who are able to interview, assess and formulate cases in which they sometimes initiate pharmacological treatments and monitor their effects. Other colleagues who work in such ways agree with me that it has revolutionised the dynamics of the team. I have a pharmacist working in the team with a clearly defined medicines management role. Yes, this can sometimes cause conflict, but it provides a useful scientific backdrop or framework and helps to balance the team. It helps keep governance and innovation in balance. The pharmacist works with the team in a number of interesting ways: occasionally we hold a joint case conference with myself, the pharmacist, users and carers and care coordinator to look at particularly knotty decisions about choice of medication. It's a long way from a quick flick through 3 volumes of notes at a busy outpatient clinic to find "an antidepressant you haven't been on yet!"

Sometimes, I refer to the pharmacist for advice for a detailed report and discussion on medication choice. He will supply me with a review and references to the evidence base backing that up. Some colleagues have grimaced at this process wondering why, as a consultant, I should be seeking advice in this way. I really don't think I need to answer their criticisms, as such, having seen too many of the same colleagues hit problems by not communicating and seeking opinions. Let's be honest, the average senior pharmacist has a much more detailed knowledge of pharmacology, pharmaco kinetics and the scientific background to medication than the average consultant psychiatrist, who granted is the acknowledged expert in the application of that knowledge in a clinical setup. Another example of where a team approach is the optional delivery format; and one in which trust and respect for colleagues in other disciplines is called for.

Our pharmacist makes a great show of criticising the previous approach of his profession; hiding behind lab coats, occasionally peering out from behind the dispensing counter, avoiding patient contact, counting pills and tutting at prescription errors by doctors. He is aware that just like all other professions, pharmacy needs to optimise and align its skill base for the better good of our users and carers.

I am developing a love of doing things differently and confronting tradition and prejudice. I have a colleague who is a Staff Grade, who has for years worked in a very holistic manner. She has taken the unusual step of wanting to be a care coordinator and is learning many of the skills that traditionally would have been owned by a nurse or social worker. With her extensive range of physical medical skills she is probably going to become our first proper care coordinator from a medical background within the trust, maybe even nationally.

What we are trying to create is a team with a much broader generic skill base which on a day to day basis allows me to occupy a more specialist position as consultant advisor to the team and chief practitioner for the most highly complex and difficult cases. I now spend much more of my time concentrating on the top end of the scale, grappling with the difficult to engage, highly complex cases with co-morbid physical illness, instability and high risk. As this is now my clinical focus and I am not cluttered up with lots and lots of maintenance and routine monitoring, I enjoy it so much more. The team see me now as a highly specialist resource which is now more accessible as opposed to someone they had to hunt down and corner. I used to feel like an animal pursued by a pack at one time.

I no longer do outpatient clinics and see all of my patients at the request of the team. Hence the need for access to my electronic diary. People treat that privilege with so much respect, they can see now what I have to do and adjust accordingly.

So the morning is spent discussing the referrals and the management of recent cases. I feel quite secure in my specialist role to such an extent that we have even begun discussions on the importance of team leadership not just being a function occupied by the consultant psychiatrist. I think we are going to experiment with rotating the team leadership and team development role between some of the professions. Sometimes being brave like that, I believe can enhance status, respect and position within a team.

The afternoon is spent seeing patients.

I don't do a clinic. I won't see anyone unless they are accompanied by their care coordinator at the very least, and often I see them with several key people including their carers. I may see them at the team base, I may see them at home, it is very interesting; it's very varied and it means that I have enough time to do things I need to do. The team know when I am available, they fit people in for me to see and they make sure that all the information I need to know is available. They also know that I will not routinely follow up these patients but at the end of my intervention, I will effectively hand over the case back to the care coordinator and trust them to monitor the situation and bring it back to me as appropriate. This system is working spectacularly well although the patients needed to be reassured at the start that they would see me when they needed to, not just when I wanted to see them.

Seems obvious now, but why should contact with a psychiatrist be based on my needs rather than theirs. I am told it is called "person centredness".

Tuesday 7th November 2006

Tuesday is my "complex morning" when I although I don't do clinics as such, I put aside time to work on my most demanding cases. They often have co-morbid neurological problems and I often need to set up case conference type facilities to pull together the mass of information required to really get to grips with these problems. Although I don't interview the patient in the presence of a mass of people, the meetings often become a teaching and learning experience for everybody. They are becoming very popular with all types of clinicians in training. I leave myself time at the end of the morning and throughout the afternoon in case there are any emergency assessments but to be honest the team is now so competent that they will respond without informing me and have developed a style which suits me well. In effect they go away, assess a situation, come up with some initial solutions and then present me the information in a useable form. It used to stress me enormously when people from the team in a helpless and inefficient way would present crises to me to be solved. Now they do most of the solving themselves and present me with usually an almost fully worked out solution. This then allows me to be much more effective in taking the clinical resolution to the next stage.

The afternoon is really quite a joy as I am not burdened with hundreds of routine outpatients; I have been able to set aside time for teaching and training. I insist that the training forum is multidisciplinary as I am trying to bring up the junior doctors in a culture of team working experience. They do almost no unidisciplinary training nowadays with me as I believe that the young doctors of the future will be expected to deliver their care almost exclusively in a multidisciplinary setting. The teaching session this afternoon concerns the integration of formulation skills with prescribing effectiveness and the delivery of physical forms of treatment as an adjunct to psychological therapies. We all regard this as a highly effective and truly "joined up" way of delivering mental health care.

Wednesday 8th November 2006

The morning is spent in liaison with the in-patient service. Since I gave up in-patients, and handed over their care to a colleague who specialises in that environment there have been massive changes. It helps that I trust my consultant psychiatrist colleague and that we work as team. It would be dreadful to hand over

a well known patient in crisis for there to be a complete change of care plan which I would then want to change upon their discharge. We have overcome these difficulties by developing a close working relationship. The care coordinators and myself regularly visit our patients on the wards and input into the care planning meetings. There are no ward rounds anymore, only timetabled sessions when the in-patients are discussed, a note of which I get in my electronic diary. My colleague is a bit of a technology freak and insists on interviewing his patients by video link to the rest of the team to avoid the old horror of the in-patient being marched into a room containing 15 people of whom they would know very little. Generally speaking I have found that as long as there is clear communication between the different parts of the functionalised service there is less room for dispute and poor coordination. People don't seem to fall down the gap nowadays like they used to and there is a developing sense of hand over in crisis or perhaps more accurately loaning to another part of the service knowing that you will be given them back again in a form which is not alien.

In the afternoon I spend my time on service development with the clinical director and the general manager. This is a rare treat as at one time I had my head down so far that I had no idea what strategy meant.

The presence of the in-patient continuity team has also greatly increased the physical health care to the in-patient environment. Apart from the fact that my Medical Director tells me that we now no longer live in fear of falling foul of the European Working Time Directive and New Deal and its punitive banding structure we now have a team of competent individuals from different professions all trained in physical examination and rapid tranquilisation who are coordinated to respond to the wards. The junior doctors play their part in this but sometimes it is the nurse practitioner who comes to see a patient, initiates treatment and reports back to a centrally coordinated service. The days of chasing the junior doctor, who is off site, not answering his bleep or had swapped with a colleague are now long since gone.

Another crucial intervention has been the realignment of our nurse consultants. They used to have really quite poorly defined professional identities. Nobody knew exactly what they were supposed to be doing and even they themselves were aware of the limited impact on services. Since they have been realigned into a clear role of operational service modernisers they deliver much more benefit. In effect within our trust now they operationalise NWW in the clinical environment and have links with our strategic modernisation committee.

It has been an enlightening experience to be involved in such work developing services within the directorate and being aware of the financial implications. What is fascinating is observing the culture shift which has occurred. The in-patient unit is now a very different place. Sure it is more disturbed in that we are only admitting the most severely ill people; but with a dedicated in-patient consultant there is now a sense of owned culture within the ward with some interesting knock on effects. The general manager was showing me the reduction in sickness absence over the last 12 months which I believe can be directly related to the sense of ownership and coherent identity developing within the services.

Thursday 9th November 2006

The morning was pretty much the same stuff seeing patients with some team members and a home visit. It was relatively quiet so I was able to catch up with a bit of administration, checking my emails and making sure that all communications were up to scratch. Over lunch I had an interesting meeting with the clinical director and some of the new commissioners. To be honest a year ago I didn't really know what commissioners were but in this new environment they are very anxious to liaise with the clinicians providing front line care. As our Chief Executive explained we are in the business of providing a service to our users and carers and to our commissioners which needs to be marketable. If we are going to achieve income as a Foundation Trust as we now are, we have to produce the products that the commissioners want to buy and which are acceptable to our users and carers. In order for the commissioners to join up the pieces they need to know what sort of services are available and effective. I have to say they are very impressed with our approach and the fact that they can now walk into a meeting with a psychiatrist who is not simply complaining about lack of resources, who is overworked, over stressed and complaining about being told what to do by management. In effect the team ethos has spread from the clinical setting into the managerial setting.

In the afternoon I spend the early part supervising one of our nurse led clinics. They are pretty competent and don't require much input but they want to discuss several cases particularly issues related to physical health and medication. I run this supervision service jointly with the pharmacist who sometimes disapproves of my prescribing practice but generally speaking we have learned to get on and he is enjoying the benefits of working at the clinical interface as opposed to just putting pills in bottles.

Towards the end of the afternoon I had a telephone conversation with a local coroner. I think that the legal profession is finding it hard that the mental health services are undergoing a considerable change. Coroners have the tendency to always assume that should they require any information on an unexpected death it comes from the medical practitioner. I was able to explain that in many cases this would be person they would want to speak to or receive a report from however, nowadays with the enhancement of the role of care coordinator it might be equally feasible for them to just seek evidence from such an individual. I think it is going to be a long slog with the legal eagles as they tend to be quite conservative by nature, but at least the coroner agreed to a face to face meeting in a couple of weeks time.

Friday 10th November 2006

Friday is usually my tidying up day for the weekend although on this occasion I spent the day at a National Conference. My working week has become much more flexible and the community team is now so competent that they are quite happy when I disappear off to other parts of the country. They have a point of contact in one of my colleague psychiatrists but they rarely call them and resolve themselves and tell me about it later. In fact they often email me when I am away just to say what they are doing and I find myself answering the odd message on the Blackberry sometimes in the back of a taxi or on the train. This flexibility of working and availability at distance works well for me and the team although it does require them to know that you will respond if necessary and speedily.

The conference? Well that was about NWW and I was presenting my experiences of the first year of practising in this way. I met some hostility and it never ceases to amaze me just how inhibited some people can be. I was faced with two or three consultant colleagues from different parts of the country who were telling me that it was not possible to work in this way. I had the perfect answer of course that me and my team were living examples of just how effective it could be. Some colleagues seem to find it difficult that caseloads can be reduced and that patients will survive without seeing a psychiatrist every 3 months for 5 minutes. Some find it difficult to believe the other professions can be effectively trained in what were traditionally medical roles. Some other professions don't want to enhance their clinical skill base and don't want to feel like "mini doctors".

To me it all seems fairly clear. The central point of future mental health clinical teams will be the care coordinator. They will have a broad clinical skill base and be responsible for guiding the patient around the care pathway. The future role of the consultant psychiatrist is as a highly specialised clinician positioning themselves at a different point in the care pathway and being an accessible and flexible resource with a skill base orientated towards complex cases, a number of whom they will treat clinically and a larger number of whom they will provide consultancy services for. This will allow them to further enhance their leadership skills and strategic management capacity in the developing services.

As I say to some of my colleagues "in order to climb a ladder you also need to let go one hand at a time". Some of the colleagues that I see are still gripping tightly to the rung they were stuck on several years ago.

I came home from the conference and had a nice glass of Pinot Grigio and switched off my Blackberry, but maybe I'll have a peek at it later on if my wife's not looking!

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 9

DIARY SHEET

Please complete the diary sheet on 2 different days during 2 different weeks to ensure a good representation of your activity. The aim of this exercise is not to monitor time spent but to support you to begin to consider the tasks and activities you currently undertake and if they could be undertaken more appropriately/effectively by someone else.

* **Please enter your own times to fit in with your normal working hours**

*Time	Task/activity/ intervention	Was it effective/what were the outcomes?	Could this be undertaken more appropriately/effectively by someone else? If yes, who and what needs to change

Please photocopy more as required

STEP 1: PREPARATION AND OWNERSHIP – HANDOUT 10

STEP ONE SIGN OFF

To be completed by the team leader and forwarded to the facilitator prior to commencement of Step 2

- All the information detailed on the checklist has been collected and collated
- All the team members have received, and had an opportunity to read, The service user and carer involvement, NWW, New Roles and Diary of a NWW Consultant Psychiatrist handouts
- The team have a clear plan for involving service users and carers
- All team members have an understanding of the 10 ESCs
- All team members have completed the individual diary sheets
- All the team members have received adequate information about the CCTA process
- All the work required in Step 1 has now been completed

Signed .....

Name .....

Date .....

Contact Details .....

STEP 1 – PREPARATION AND OWNERSHIP CCTA PRESENTATION

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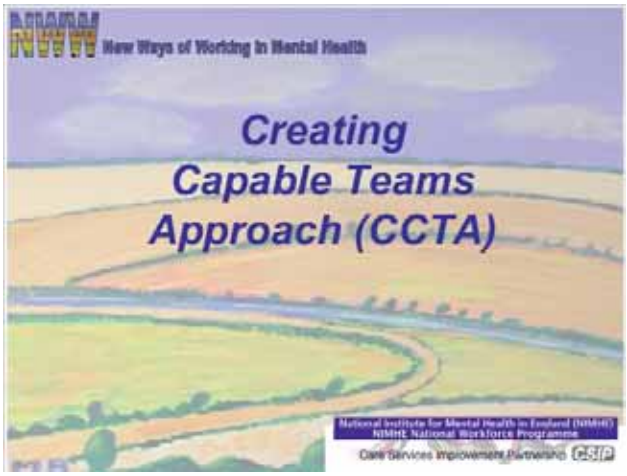

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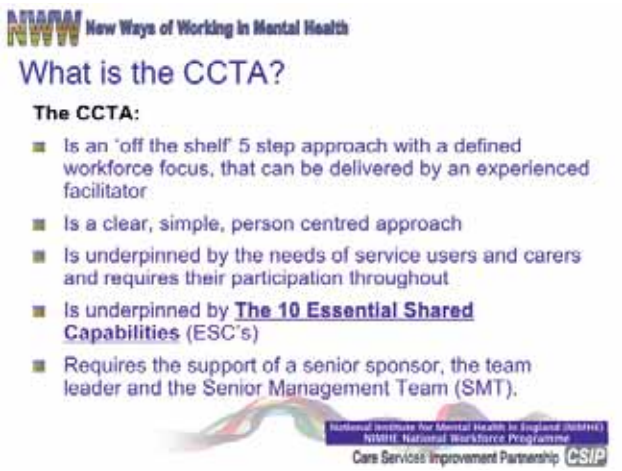

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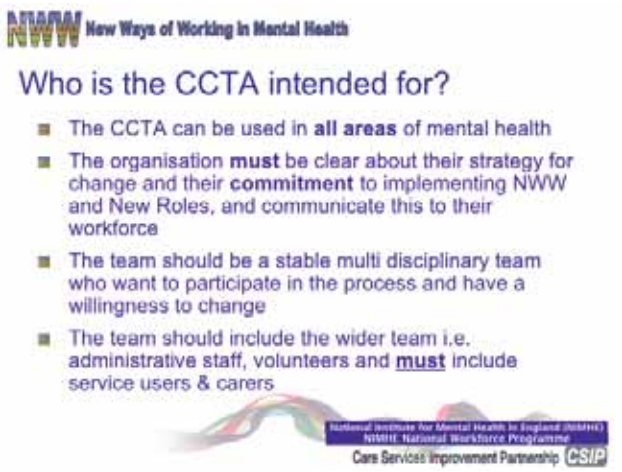

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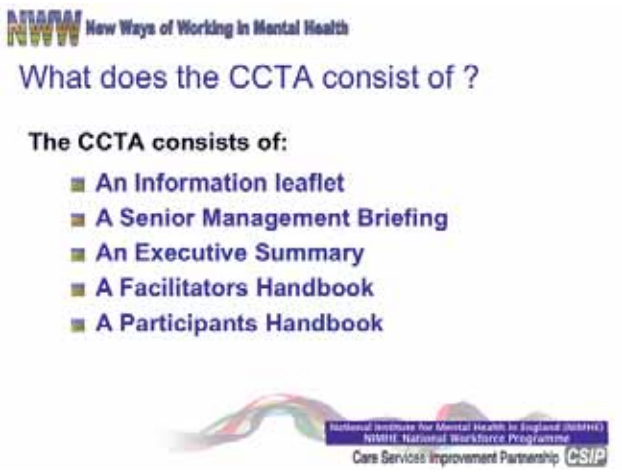

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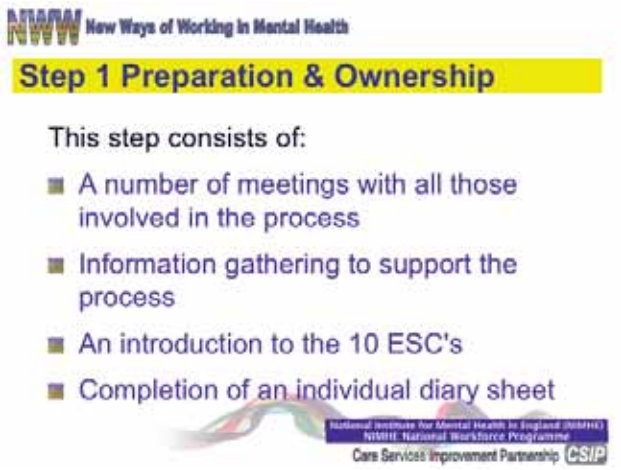

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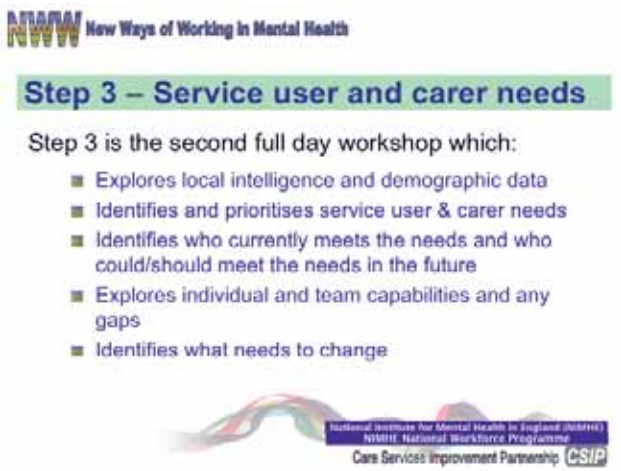

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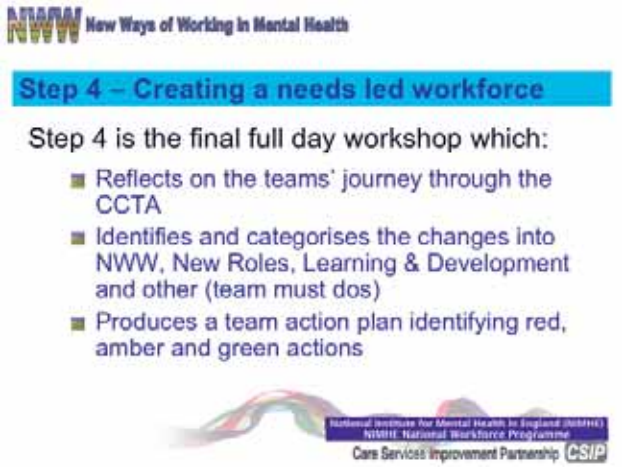

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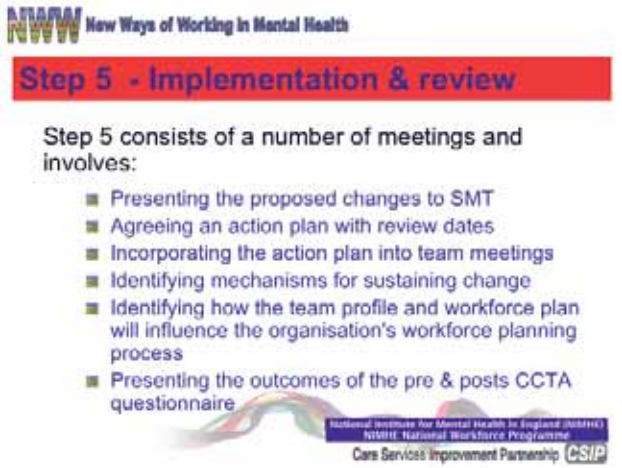

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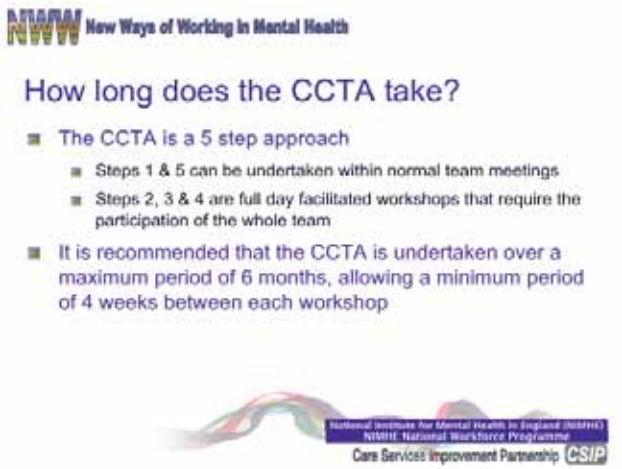

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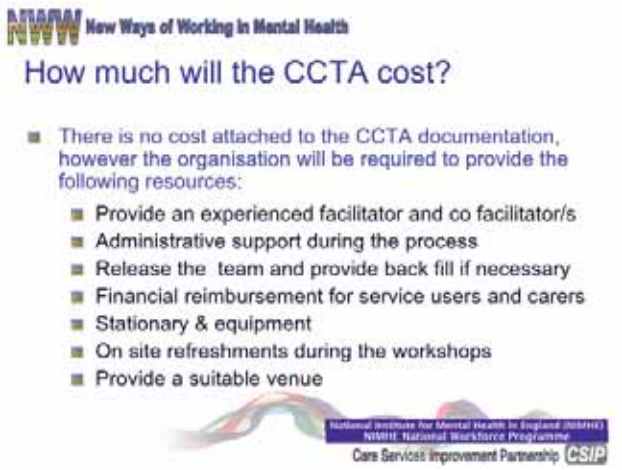

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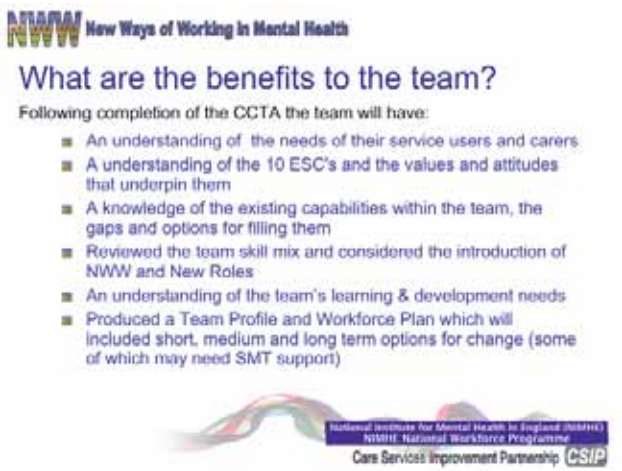


Slide 19

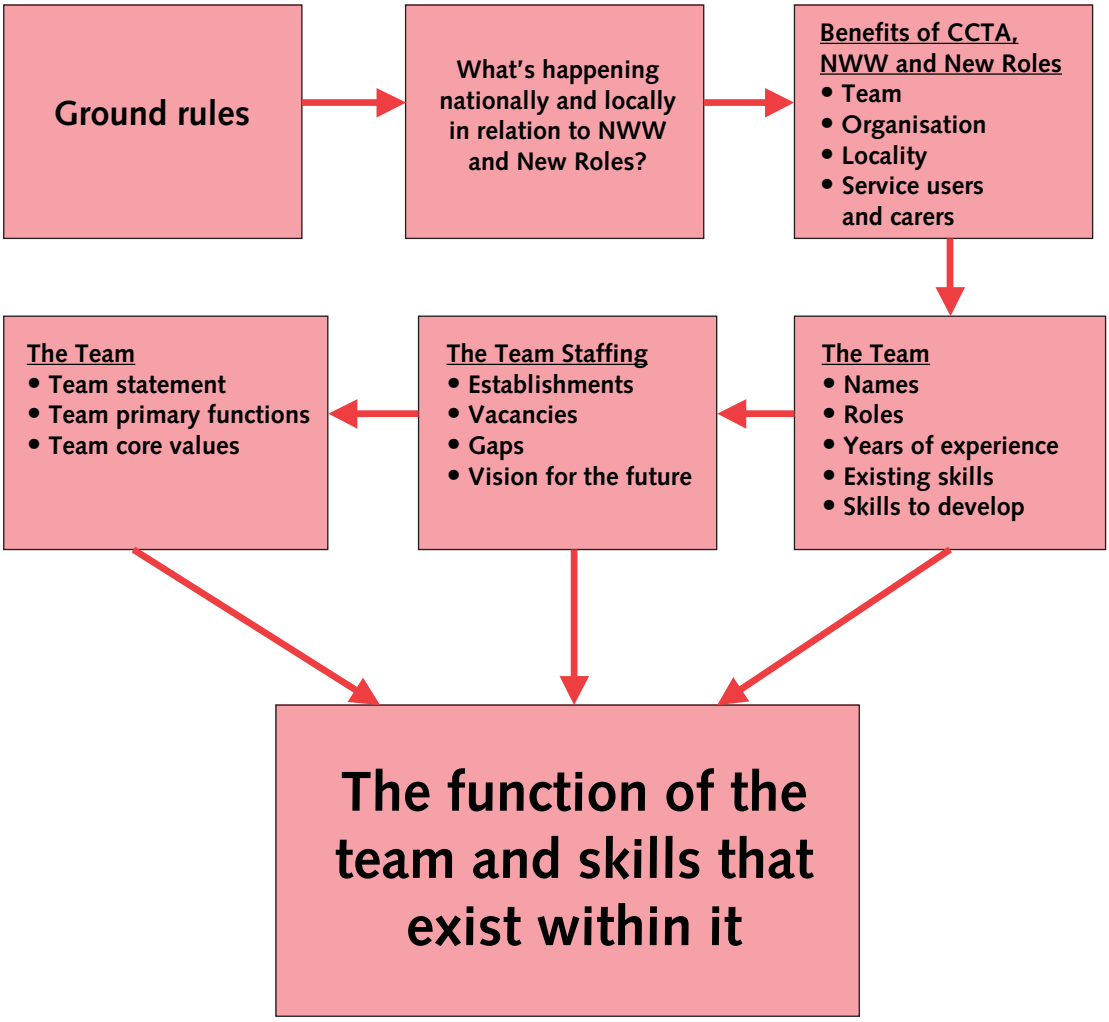

New Ways of Working in Mental Health
What are the benefits to the organisation?
The opportunity to provide cost effective, value for money services
The opportunity to develop a needs led service which incorporates NWW and New Roles
To be able to influence learning and development programmes by being clear about the capabilities required
To have a clear picture of the range and level of activity required to deliver the service
The development of a team profile and workforce plan which will contribute to the organisations workforce planning processes and support Foundation Trust status
NIMHE National Workforce Programme
Care Services Improvement Partnership
CSIP

Step 2: Team Function

CONTENTS

Step 2: Team Function (Workshop 1)

Workshop Pathway



Step 2: Team Function (Workshop 1)

PARTICIPANT'S PROGRAMME

Aims of the day

The aims of Step 2 are to:

- Understand the CCTA process and the aims of Step 2
- Clarify dates and timescales for the CCTA process
- Establish and agree ground rules for the workshops
- Get to know each other better
- Understand the national context and local drivers
- Clarify the make up of the team and highlight any issues
- Clarify the primary function and operational policy of team
- Gain an initial insight into the skills, experience and qualifications within the team

9.15	Arrival and Beverages	Handouts
9.30	**SESSION 1 – Introduction to Step 2**	
	Introductions to each other Completion of pre-workshop questionnaire Introduction to CCTA, Step 2 and Team profile and workforce plan Confirmation of CCTA timetable Feedback from Step 1 Identify buddies for absent team members Collection of information gathered in Step 1 Discuss 10 ESCs and record any learning outcomes on flip chart **Outputs from session – flip chart identifying any learning outcomes from the 10 ESCs and completed pre-workshop questionnaire**	**2. Pre workshop questionnaire** **3. Buddy record** **4.Team profile and workforce plan**
10.15	**SESSION 2 – Establishing the ground rules**	
	Each team member to note down 2 ground rules Feedback to facilitator who will record on flip chart **Outputs from session – flip chart of ground rules**	**None**
10.45	**BREAK**	
11.00	**SESSION 3 – National and Local Context**	
	NWW and New Roles presentation What are you doing locally in relation to NWW and NR? Identify 2 things the team could do and how the CCTA could support this. Split into 3 groups and spend 10 mins listing the benefits and motivators for undertaking the CCTA and introducing NWW and NR for: • The Service users and carers • The Team • The Organisation • The Locality Feedback to facilitator who will record on a flip chart **Outputs from session – 5 flip charts identifying what's happening/ what could happen locally. benefits and motivators for the service users and carers, the team, organisation and the locality**	**NWW and NR Presentation and handout**

11.45	**SESSION 4 – Something about me**	
	Complete the following statements on the something about me handout (please be aware you will be required to share these with the group) • ***My name is ……..*** • ***The skill I bring to the team that I am most proud of is…..*** (remember it is often difficult to blow your own trumpet) • ***I would most like to develop my skills in ……..*** Feedback to facilitator to record on a flip chart **Outputs from session – 2 flip charts identifying existing skills and skills to develop**	**5. Something about me**
12.15	**LUNCH**	
1.00	**SESSION 5 – Individual Contributions**	
	Choose a partner – if possible someone who you do not usually work with or know that well Decide who is **A** and who is **B** **A** should interview **B** for 3 mins recording on the individual contributions handout their partners: • Name • Role • Number of years experience in MH services • The skills, experience and qualifications they bring to the team **DON'T BE MODEST but please be aware you will be asked to share this information with the large group!** Swap over and **B** should interview **A** for 3 mins as above Introduce your partner stating their name, their role, number of years experience and the skills, experience and qualifications they bring to the team Feedback to facilitator who will record on a flip chart **Outputs from session – 4 flip charts listing names and number of years experience, roles, skills and experience and qualifications**	**6. Individual contributions**

1.45	**SESSION 6 – The Team Staffing**	
	The team leader will present the team establishment information gathered in Step 1 **As a team explore:** • Where are the gaps? • Is there the right balance of staff? • What are the implications? • How could it be in the future? • How would you get there? • How could you use the vacancies? Feedback to facilitator to record on a flip chart **Outputs from this session – 2 flip charts identifying the team's establishment and providing an initial analysis about the composition of the team**	**None**
2.30	**BREAK**	
2.45	**SESSION 7 – The team function**	
	Divide into 3 groups and complete the following statement *The team provides* ***(type of service)*** to ***(males/females)*** *with an age range of* ***(18–64)*** in the area of ***(central Hull)*** *between the hours of* ***(9–5)*** *on* ***(Mon–Fri)*** ***The primary functions of the team are:……*** ***The 5 core values of the team are:……*** Use the team function handout and operational policy to help you focus taking into consideration: • How the team's operational policy and any policy implementation guidance compares with the way you work • Must dos – any contractual agreements/service level agreements/ national policy • Exclusions – anyone the team does not provide a service for i.e. people with a personality disorder or learning disabilities Discuss the statements as a team and come to an agreed definition Feedback to facilitator who will record on a flip chart **Output from this session – 4 flip charts identifying the agreed team statement, the team's primary functions, 5 core values and other relevant issues**	**7. Team Function** **Team's operational policy (gathered in Step 1)** **Any relevant policy implementation guidance (gathered in Step 1)**

3.30	**SESSION 8 – Summary of Step 2**	
	The facilitator will draw the workshop to a close by reflecting on the work the team have done to date which will include the following outputs: • **Ground rules** • **Benefits and motivators** • **What's happening/what could happen locally** • **Existing skills** • **Skills to develop** • **Names and years of experience** • **Roles** • **Skills and experience** • **Qualifications** • **Team establishment** • **Team statement/function/values** • **Team must dos and exclusions**	
3.45	**SESSION 9 – Preparation for Step 3 and evaluations**	
	Prior to the Step 3 all participants should read the following handouts again: • The NWW and New Roles handouts and follow up the relevant links that provide more in-depth information about the roles • The diary of a NWW Consultant Psychiatrist • Their individual diary sheets completed in Step 1	
	Evaluations	
	Please complete your evaluation forms and hand to the facilitator prior to leaving the workshop	**8. Evaluation form**
4.00	**FINISH AND COFFEE**	

STEP 2: TEAM FUNCTION – HANDOUT 2

PRE-WORKSHOP QUESTIONNAIRE

This questionnaire is designed to provide information to help us to identify your needs and refine the CCTA approach further. Please compete the questionnaire prior to commencing the workshops and return to the CCTA facilitator before:

Date:

Role
Service Area (CAMHS, In-patient etc)
Type of Organisation (NHS/Voluntary Sector etc)

For each of the following statements, please indicate how true it is for you, using the following scale: 1 = Not true at all 2 = May be true 3 = True 4 = Very True

A	Participation and Choice	Score
1	I think I will enjoy completing the CCTA	
2	The CCTA workshops seem like fun to do	
3	The CCTA process seems about the right length of time	
4	I believe I have some choice about doing this activity	
5	I believe the CCTA will be of some value to me	
6	I will do the CCTA because I want to	
7	I think myself and the team will benefit from undertaking the CCTA	
8	I will be willing to undertake any ongoing work to support the implementation of the CCTA action plans because I think they will be of some value to me	
	(Maximum Score 32) Section A Score	
B	**Preparation**	
9	I feel I have been well prepared for undertaking the CCTA	
10	I feel that the all the team members have a good understanding of the CCTA process prior to commencing the workshops	
11	I feel that the organisation is supportive of the CCTA process and has a good understanding of their role within it	
	(Maximum Score 12) Section B Score	

C	Knowledge and Understanding	
12	I feel I will be able to apply the principles of NWW and New Roles well within the team	
13	I think the SMT will support the actions identified	
14	I think the team will be capable of implementing any actions for change identified during the CCTA process	
15	I feel confident about my knowledge and understanding of NWW and New Roles	
16	I have a good knowledge about the local population the team serves	
17	I feel I have a good knowledge and understanding about the needs of the service users and carers the team serves	
18	I think that the CCTA is important because it will improve services for service users and carers	
19	I think that doing the CCTA will be useful for improving my practice and that of the team as a whole	
20	I have a good understanding about the skills, knowledge and experience within the team	
21	I feel that the CCTA will improve the workforce planning process within the organisation	
	(Maximum Score 40) Score from Section C	
	Total Score from Section B	
	Total Score from Section A	
	(Maximum potential score 84) Overall total score from A, B and C	

Additional information Are there any other comments/learning experiences you would share about the CCTA?
Date Completed

STEP 2: TEAM FUNCTION – HANDOUT 3

BUDDY RECORD

If a team member is unable to be present at a meeting/workshop a buddy should be identified and their name recorded. It will be the buddy's responsibility to ensure all information, including handouts, is fed back to the absent team member. This information should be recorded below.

Absent team member	Buddy

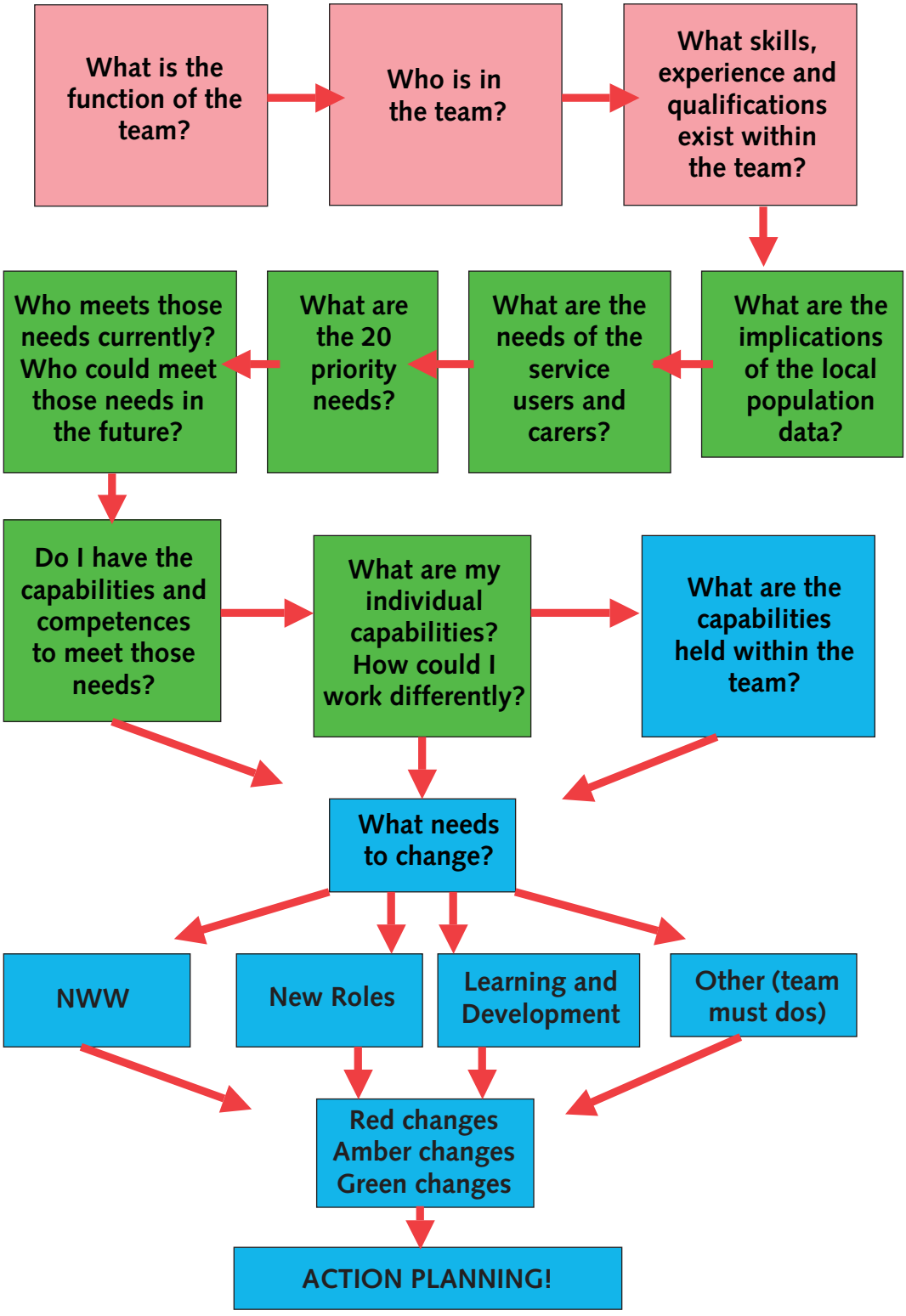
STEP 2: TEAM FUNCTION – HANDOUT 4

CREATING CAPABLE TEAMS APPROACH (CCTA)

Team Profile and Workforce Plan

Team		
Base		
Team Leader	Name	Contact Details
Senior Sponsor		
Facilitator		
Date commenced CCTA		
Date completed CCTA		

Workshop pathway



STEP 2: TEAM function

NATIONAL AND LOCAL CONTEXT

What's happening locally in relation to NWW and New Roles?

What could happen locally in relation to NWW and New Roles?

Benefits and motivators for undertaking the CCTA and introducing NWW and New Roles
For the service users and carers:

For the team:

For the organisation:

For the locality:

The team		
Name (A)	**Role (B)**	**Number of Years' Experience**
		Total

Existing skills, knowledge and experience within the team

Existing qualifications

Skills and knowledge to develop

The team staffing	
What is the team's agreed establishment?	
What is the team's current establishment?	
What number of vacancies currently exists within the team?	

The team statement

The team's primary functions

The team's 5 core values

STEP 3: SERVICE USER AND CARERS

THE LOCAL POPULATION

Key implications for the team

Demographic information	
What population does the team cover	
What is the age profile of the population	
What is the male/female split	
What is the ethnicity profile of the population	
Is the area covered rural, urban or coastal	
Is there any local intelligence/trends that may affect the service the team delivers	

Population size

Geography

Age profile

Ethnicity

Employment status

Male/female mix

Local intelligence/trends

THE NEEDS OF THE SERVICE USERS AND CARERS

The Green Needs of the service users and carers

The Amber Needs of the service users and carers

The Red Needs of the service uses and carers

THE 20 **PRIORITY** NEEDS OF OUR SERVICE USERS AND CARERS

Priority Needs		Who currently meets the need	Who could/should meet the need
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Suggested changes		
Change	**By whom**	**By when**

STEP 4: CREATING A NEEDS LED WORKFORCE

WHAT NEEDS TO CHANGE?

What needs to change to meet the 20 priority needs? (Based on the information gathered on the diary sheets, individual capability profile, working differently handout and team capability profile)

New Ways of Working

New Roles

Learning and Development

Others (team must dos)

TEAM CAPABILITIES

Change/staff initials																					
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
7.																					
8.																					
9.																					
10.																					
11.																					
12.																					
13.																					
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16.																					
17.																					
18.																					
19.																					
20.																					

✓ = Have and need X = Don't have and don't need N = Need but don't have H = Have but don't use
C = Could do in the future D = Need to develop/improve

All identified green changes

All identified amber changes

All identified red changes

2 RED PRIORITY CHANGES (to take to SMT)

Workforce Action Plan

Green changes	By whom	By when	Resources required

Creating Capable Teams

Workforce Action Plan

Amber changes	By whom	By when	Resources required

Creating Capable Teams

Workforce Action Plan

Red changes	Proposals	By whom	By when	Notes

Creating capable teams

Workforce Action Plan

Changes to be taken to SMT

Red changes	Proposals	By whom	By when	Notes
1.				
2.				

The Team Profile and Workforce Plan is completed throughout the CCTA capturing the team's journey from Step 1 to Step 5. The final document will identify:

- The team staffing, function and core values
- The skills, knowledge, qualifications and experience within the team
- The key implications of the local population
- The domain needs of the service users and carers
- The 20 priority needs of the service users and carers
- How the needs are currently being met
- What needs to change to improve the way the service is delivered in the future ensuring that:
  - **It meets the needs of the service users and carers**
  - **It is cost effective and value for money**
  - **Resources are being used effectively**

Specific aspects of the team profile and workforce plan will be relevant and informative to a variety of departments within the organisation e.g.

- Workforce planning
- Workforce development
- Operational services
- Education and training departments

Although key information can be subtracted from the document it will also be a valuable source of information to share the complete document to demonstrate how the team arrived at the final actions.

The TPWP should also be retained and used by the team as a template to measure, support and evidence change, whilst also acting as a benchmark for the future

STEP 2: TEAM FUNCTION – HANDOUT 5

SOMETHING ABOUT ME

Complete the following statements **(please be aware you will be required to share this information with the group)**:

My name is:

The skills I bring to the team that I am most proud of are:
I would most like to develop my skills in:

STEP 2: TEAM FUNCTION – HANDOUT 6

INDIVIDUAL CONTRIBUTIONS

My partner's name is (full name please):
Their role in the team is:
The number of years experience they have in Mental Health services is:
The skills, experience and qualifications they bring to the team are:

STEP 2: TEAM FUNCTION – HANDOUT 7

THE TEAM FUNCTION

Each group should complete the following statement:

The team provides …… to ……

with an age range of ……in the area of ……..

between the hours of ……on ……

The following guidance may help you focus

What service does the team provide?

- E.g. AOT, CRS, CMHT, In-patient

Who does the team provide a service to?

- Male/Female
- Age range
- Ethnic mix

What area does the team cover?

- Name the locality/patch the team covers

When does the team provide a service?

- During what times
- What days

Now take some time to consider:

What are the primary functions of the team ……

What are the core values of the team …….

The team should also take into consideration specific issues i.e.

- How their operational policy and any policy implementation guidance compares with the way they work
- Must dos – any contractual agreements/service level agreements
- Exclusions – anyone the team does not provide a service for e.g. people with personality disorder or learning disabilities

STEP 2: TEAM FUNCTION – HANDOUT 8

PARTICIPANT'S EVALUATION FORM

Please rate each session, indicating the extent to which you found each relevant and useful, and how well it was run

1 = not relevant/useful **5 = extremely relevant/useful**

1 = did not run well **5 = ran extremely well**

SESSION 1 – Introduction to Step 2					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5
SESSION 2 – Establishing the ground rules					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5
SESSION 3 – National and local context					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5
SESSION 4 – Something about me					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5
SESSION 5 – Individual contributions					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5
SESSION 6 – The team staffing					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5
SESSION 7 – The team function					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 8 – Summary of Step 2					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

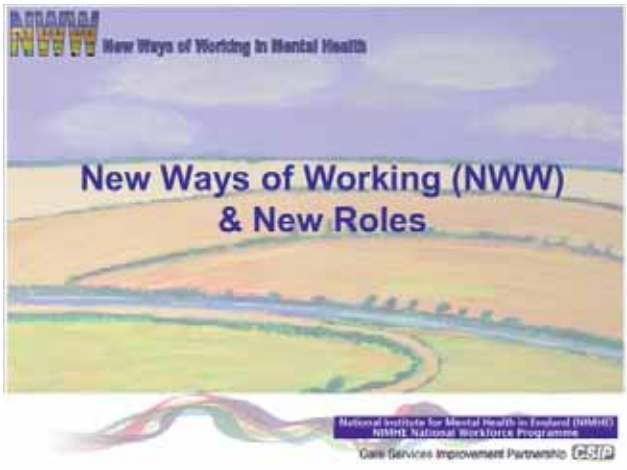
The best things about the day were:

The least satisfactory things about the day were:

What advice would you give about how the day could be run better another time?

STEP 2: TEAM FUNCTION NEW WAYS OF WORKING PRESENTATION

Slide 1



Slide 2

Slide 3

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Step 3:
Service User and Carer Needs

CONTENTS

Step 3:
Service User and Carer Needs

Step 3:
Service User and Carer Needs

STEP 3: SERVICE USER AND CARER NEEDS (Workshop 2)

PARTICIPANT'S PROGRAMME

Aims of the day

The aims of Step 3 are to:

- Review Step 2 and identify aims of Step 3
- Understand the team's local population
- Establish and prioritise the needs of the service user and carers
- Identify who does/could/should meet the needs
- Determine what capabilities already exist within the team/are required by all team members/are only required by specific members of the team/are required but don't exist/are held but not known
- Begin to examine how the team could work differently to meet the needs of service users and carers

9.15	**Arrival and beverages**	
9.30	**SESSION 1 – Introduction to Step 3**	**Handouts**
	Reflect on the activity and outputs from Step 2 and discuss any issues that arise You will be informed of the day's programme and buddies identified for absent team members	**2. Buddy record**

10.00	**SESSION 2 – The local population**	
	The Team Leader will present the local population and any local intelligence gathered in Step 1 The team will brainstorm any other local intelligence/trends they are aware of and these will be added to the flip chart Divide into 3 groups and consider the data presented by the team leader and record on a flip chart any key implications for the team under the following headings: • Population size • Geography • Age profile • Ethnicity profile • Employment status • Male/Female Mix • Local intelligence/trends (e.g. new estates) Feedback to facilitator who will record on the appropriate flip chart **Outputs from session – 7 flip charts which identify key implications for the team**	**None**
10.30	**BREAK**	
10.45	**SESSION 3 – Identifying service user and carer needs**	
	Part A – Identifying the needs 5 blank flip charts will be placed around the room entitled **social inclusion, mental health, physical health, communication and carers** Each participant should go round the room and using a Post-it identify what they feel are the service user and carer needs under each heading (use the identifying needs handout as a prompt) Divide into 5 groups and go round and consider all the information on the flip charts and make and additions/comments One volunteer from each group to feedback the needs identified and explore with the wider group **Output from Part A – 5 flip charts identifying needs under the specific domains** **Part B – Meeting the needs** You will be provided with 5 Red, 5 Amber and 5 Green dots Spend the dots in accordance with how you feel the needs should be prioritised. You can spend all your red dots on one need if you feel strongly about it. It is up to you how you use your dots • **Red = Must do/Must meet** • **Amber = Could meet if had resources** • **Green = Should be considered, but could be met by other team/service provider**	**3. Identifying the needs**

	Output from Part B – 5 flip charts which begin to prioritise needs **Part C – Prioritising the needs** Divide into 5 groups Each group will be given one of the domain flip charts Reorganise the needs into priority order i.e. • **Red at the top** • **Amber in the middle** • **Green at the bottom** NB: the majority colour should determine the position of the Post-it **Output from Part C – 5 flip charts with needs arranged in priority order** **Part D – Charting the needs** Remain in 5 groups There are 3 flip charts on the wall headed red, green and amber Someone for each group is required to transfer the group's priority needs onto the appropriate flip chart i.e. most red dots onto red flip chart **Output from Part D – 3 flip charts headed red, amber and green needs** **Part E – Reviewing the needs** Divide into 3 groups and you will be allocated a red, amber or green flip chart As a group spend 10 minutes discussing the content of the flip chart and identifying any needs that you feel are misplaced (a member of the group should keep a note of your reasons) As a group move round the room and undertake the same exercise with each flip chart A member of the group will be required to feedback what is on the flip chart and any changes you feel should be made These will be discussed with the wider group and if a consensus cannot be agreed you should aim for a majority vote Any changes that could/should be made will be recorded by the facilitator for use in Step 4	

	Output for Part E – 3 flip charts headed red, amber and green needs **Part F – Priority needs** The aim of this part is to identify 20 priority needs, these will be predominantly made up of those on the red flip chart. However they may also consist of some amber and green needs depending on the number of red needs that have been identified Remaining in your 3 groups someone from the red flip chart should number all the needs 1–20 • If there are more than 20 they should be prioritised according to the number of red stickers • If there are less than 20 ask someone from the amber flip chart to transfer some of their needs in priority order to the red flip chart • If you still do not have 20 needs transfer some of the green needs in priority order onto the red flip chart You should now have a red flip chart identifying up to 20 priority needs that you are going to work on All the other needs will be recorded in the Team profile and workforce plan so they do not get lost **Output from Step F – A red flip chart identifying up to 20 priority needs, 2 further flip charts identifying amber and green needs**	
12.45	**LUNCH**	
1.30	**SESSION 4 – Meeting service user and carer needs**	
	Part A – Who meets the needs There will be 4 flip charts numbered 1–4 and divided into 3 columns – needs, who meets, who could/should The 20 priority needs from session 3 will be distributed evenly across the flip charts You will be asked to move round the flip charts identifying the name of the person who meets those needs currently **Outputs from Part A – 4 flip charts that identify priority needs and who meets them currently** **Part B – How could/should the needs be met** Divide into 4 groups and you will be given one of the 4 priority needs flip charts Using the NWW, New Roles and Meeting the needs handouts and your individual diary sheets to support the process, as a group reflect on how the needs are being met and consider who could/should meet the needs in the future and record on the flip chart next to the need A member of the group will be required to feedback and there will be an opportunity to discuss further with the wider group Any changes that could/should be made will be recorded by the facilitator for use in the next workshop **Outputs Part B – 4 flip charts that identify priority needs, who meets them currently and who could/should meet them in the future**	**NWW and New Roles (from Step 1)** **4. Meeting the needs** **Your individually completed diary sheets from Step 1**

2.30	**BREAK**	
2.45	**SESSION 5 – Identifying changes**	
	Part A – Team Activity Divide into 4 groups and entitle a flip chart suggested changes You will be given one of the priority needs flip charts from Session 4 and any changes proposed during previous sessions will be available to see Consider the information on the priority needs flip charts and make a note of any suggested changes As a group leave your flip charts and move round to the next one and carry out the same process until you have moved round all 4 flip charts **Outputs from Part A – 4 flip charts identifying suggested changes** **Part B – Individual capabilities** Each staff member will be asked to complete the individual capability profile and a working differently handout (A) Each Service user and carer will be asked to complete a working differently handout (B) The completed handouts will be required to support the preparation for Step 4	**5. Individual capability profile** **6/7. Working differently (A and B)** **NWW and New Roles (from Step 1)** **8. Capabilities and competences**
3.30	**SESSION 6 – Summary of Step 3**	
	The facilitator will draw the workshop to a close by reflecting on the work the team have done to date which will include the following outputs: • **Key implications for local population data** • **Red, amber and green service user and carer needs** • **Any suggested changes to meet the needs** • **20 priority needs** • **Who currently meets the needs** • **Who could/should meet the needs** • **Any suggested changes**	
3.45	**SESSION 7 – Preparation for Step 4 and evaluations**	
	Prior to Step 4 each member of the team will be required to: Reflect on step 3 and make a note of what needs to change individually and as a team Read the NWW, New Roles and Capabilities and competences handouts Consider the changes they have proposed and start thinking about actions and bring any proposed changes and actions to Step 4	

	Evaluations	
	Please complete your evaluation forms prior to leaving the workshop	**9. Evaluation form**
4.00	**FINISH AND COFFEE**	

STEP 3: SERVICE USER AND CARER NEEDS – HANDOUT 2

BUDDY RECORD

If a team member is unable to be present at a meeting/workshop a buddy should be identified and their name recorded. It will be the buddy's responsibility to ensure all information, including handouts, is fed back to the absent team member. This information should be recorded below.

Absent team member	Buddy

STEP 3: SERVICE USER AND CARER NEEDS – HANDOUT 3

IDENTIFYING NEEDS

Please note the needs below are examples only, the needs identified during this step should be specific to the service users' and carers' needs within the team's locality

Social Inclusion

Transport
Leisure
Access to internet
Housing
Income, benefits advice
Financial awareness training
Budgeting
Social network
Social and sexual relationships
Employment
Education and training
Spirituality, creativity, identity
Shopping
Race and culture

Mental Health

Respect, being listened to and valued
Access to other people with lived experience
Race and culture
Equal partners in care
Having a voice and access to advocacy
Hope and recovery focused care
Emotional support and psychological therapies
Choice in treatment including complementary therapies
Advanced directives/statements
Medicines management
Access to pharmacist
Hearing Voices Network and other self-help groups

Physical Health

Choice in treatment
Regular health checks
Medicines management including acting on adverse reactions
Access to dietitian, nutritionist, physiotherapist
Race and culture
Fresh air and access to good food
Access to GP, dentist, optician, chiropodist, hospital appointments
Exercise and access to sporting/fitness facilities
Health promotion – Healthy eating, obesity, smoking cessation, substance misuse

Communication

Genuine open dialogue
Clear and appropriate to the needs of the individual
A good variety of accessible impartial information
Inclusive person centred CPA process
Non-verbal skills
Language diversity, access to interpreter services
Race and culture

Carers

Respect, being listened to and valued
Empowerment and involvement in service improvement
Having a voice and access to advocacy
Accessible, impartial information
Equal partners in care
Emotional and peer support
Social life and leisure
Income
Race and culture
Employment
Education and training
Relaxation techniques and access to counselling and complementary therapies
Access to respite services if required

STEP 3: SERVICE USER AND CARER NEEDS – HANDOUT 4

MEETING THE NEEDS

What needs are being met

- Consider if these are needs that should be met by the team
- Are these needs that should met by other teams or service providers?
  - If yes write next to the need what needs to change to make this happen
- Are the needs being met by the most appropriate person?
  - If no write next to the need who should/could meet the needs (existing role, NWW or new role)

NB: Take into consideration the team's internal and external partners

What needs are not being met

- Why are these needs not being met?
- Should they be met by another team or service provider?
- If yes write next to the need what needs to change to make this happen
- Should the needs be met by the team?
- If yes write next to the need what needs to change to make this happen (consider NWW or new roles)

How are the needs being met?

- Do additional members of staff need to be able to meet the need?
  - If yes write next to the need what needs to change to make this happen (supervision, training implications, NWW, New Roles)
- Are there too many people focusing on one need?
  - If yes write next to the need could/should some of these roles/people be focusing on other unmet needs

STEP 3: SERVICE USER AND CARER NEEDS – HANDOUT 5

NAME …….. INDIVIDUAL CAPABILITY PROFILE

Guidance notes

Record the 20 priority needs identified by the team.

Using the capabilities and competences handout as guidance consider each need and determine if you feel you have the required knowledge, skills and experience to meet those needs to a level of competence required and expected of your role. (You may also wish to refer to your job description or KSF profile.)

Using the key below rate each need in accordance with the capabilities you have or need, highlighting what needs to change to ensure you meet the required needs effectively and safely.

	NEED	RATING	WHAT NEEDS TO CHANGE TO MAKE THIS HAPPEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			

18.			
19.			
20.			

Key To Rating

✓ = Have and need X = Don't have and don't need N = Need but don't have
H = Have but don't use C = Could do in the future D = Need to develop/improve

STEP 3: SERVICE USER AND CARER NEEDS HANDOUT 6

WORKING DIFFERENTLY (A)

To be completed by the staff team

Using the information gathered in Step 3, the development of your individual capability profile and your diary sheets please consider the following statements:

What do you feel is part of your role and is effective?

What are you doing that does not need to be done by anybody within the team?

What are you doing that you feel could be undertaken more appropriately by somebody else?

Could you supervise somebody else to undertake some of the activity you currently deliver?

What would you like to do but are unable to do at present?

What are the factors that prevent you from doing this?

Reflect on your responses and consider what needs to change to make these happen both from an individual and team perspective

STEP 3: SERVICE USER AND CARER NEEDS – HANDOUT 7

WORKING DIFFERENTLY (B)

To be completed by service users and carers

Using the information gathered in Step 3 please consider the following questions:

What do you feel are the most effective aspects of the roles identified?

What is currently being done by the team that could be done by another provider?

Who might that other provider be?

Reflecting on the information from step 3 are there any changes that you feel would support the team to meet the needs of their service users and carers more effectively?

STEP 3: SERVICE USER AND CARER NEEDS – HANDOUT 8

CAPABILITIES AND COMPETENCES

As individual mental health practitioners and professionals you will be expected to possess a certain level of competence to undertake your role. However practitioners require more than a prescribed set of competences. They need to be capable of providing the benefits of both effective and reflective practice. This requires an underpinning framework of values, attitudes, knowledge, skills and experience in addition to competences, along with an ability to apply these in practice, across a range of contexts from acute in-patient care to community-based crisis resolution and assertive outreach teams.

However identifying the capabilities required to meet the needs of service users and carers in itself does not address the levels of expertise required. So in essence, when considering **if you have capabilities to deliver** the interventions and meet the needs of service users and carers, you also need to determine **if you have the level of competence required** as dictated by your job description and profession.

Capability

For the purpose of the CCTA the term 'Capability' should be thought of as **what people need to possess** and **what they need to achieve** in the workplace i.e:

- Knowledge
- Skills
- Experience
- Values
- Attitudes

For values and evidence based capabilities relevant to **all** the Mental Health Workforce see **The Ten Essential Shared Capabilities (ESC)**
http://www.lincoln.ac.uk/ccawi/esc/esc_web/assets/index01.html

Competences

A competence framework should, as the Mental Health Occupational Standards would:

- Define the level of expertise and knowledge required within a particular domain
- Provide a measurement for 'output' or performance
- Determine the level of capability at which a role will be performed

Competence frameworks are set out in a series of National Occupational Standards (NOS) and National Workforce Competences (NWC) developed by Skills for Health, for use within the health sector. Skills for Health has completed a number of projects covering a wide variety of condition specific areas or client

group domains, including mental health, and these can be found in the Completed National Competences section on the skills for health website http://www.skillsforhealth.org.uk/

The NHS Knowledge and Skills Framework (KSF)

The NHS KSF defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff. Although not specific to mental health it can be used by mental health staff.

The NHS KSF is about the application of knowledge and skills – not about the particular knowledge and skills that you need to do your job.

The NHS KSF and its associated development review process lie at the heart of the career and pay progression strand of Agenda for Change. They are designed to apply across the whole of the NHS for all staff groups who come under the Agenda for Change Agreement.

The NHS Knowledge and Skills Framework (KSF) is a way of describing all posts in the NHS in terms of groups of skills called core dimensions and specific dimensions.

The are six core dimensions that apply to every post in the NHS. Each dimension has four **levels, which increase in complexity from level 1 to level 4.** Attached to each level are:

- **Indicators** – these describe the level at which knowledge and skills need to be applied
- **Examples of application** – illustrate how and to what the dimensions, level descriptors and indicators could be applied across the jobs in the NHS

The 6 core dimensions are:

- Communication
- Personal and people development
- Health, safety and security
- Service improvement
- Quality
- Equality and diversity

The remaining 24 specific dimensions describe a very wide range of skills, some of which will apply to individual jobs and many that will not.

For further information visit: http://www.nhsu.nhs.uk/ksf

The Ten Essential Shared Capabilities (10 ESCs)

An early priority of the National MH Workforce Programme was to address concerns expressed by people who had used services and their carers, some of which were:

- Staff did not value the contribution that service users could make
- Service users and their families were not listened to
- Service users and carers were not involved in their care planning, nor empowered
- There were no standards for the entire MH workforce to aspire to
- Training for staff, particularly in the NHS, was too narrow and clinical in its focus

Furthermore, the service user movement has articulated a vision of recovery, which has been endorsed by many practitioners and service providers; it was therefore important to issue a set of core skills for the entire workforce.

The 10 ESCs learning materials have been developed as a resource to inform practice, and so help the delivery of **mental health and social care services** in England. The focus of the 10 ESCs is on attitudes, behaviours, expectations, and relationships. They describe the values and principles that should be demonstrated or evident in the way that services are commissioned and planned, and reflect how people who use mental health services, and those who support them want, and expect, to be treated.

The 10 ESCs learning materials are a resource for everyone and are available on CD-ROM or a paper version; they provide reading materials and practical exercises and focus on the national priorities for mental health.

The 10 ESCs are:

- 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

Learning and Development

When considering your learning and development needs you should consider a variety of methods not just attendance on formal training programmes. Other options to consider are:

- Shadowing
- Mentoring
- Supervision
- Skill sharing within the team
- E-Learning
- Distance learning

STEP 3: SERVICE USER AND CARER NEEDS – HANDOUT 9

PARTICIPANT'S EVALUATION FORM

Please rate each session, indicating the extent to which you found each relevant and useful, and how well it was run

1 = not relevant/useful **5 = extremely relevant/useful**

1 = did not run well **5 = ran extremely well**

SESSION 1 – Introduction to Step 3					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 2 – The local population					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 3 – Identifying service user and carer needs					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 4 – Meeting service user and carer needs					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 5 – Identifying changes					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 6 – Summary of Step 3					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

The best things about the day were:

The least satisfactory things about the day were:

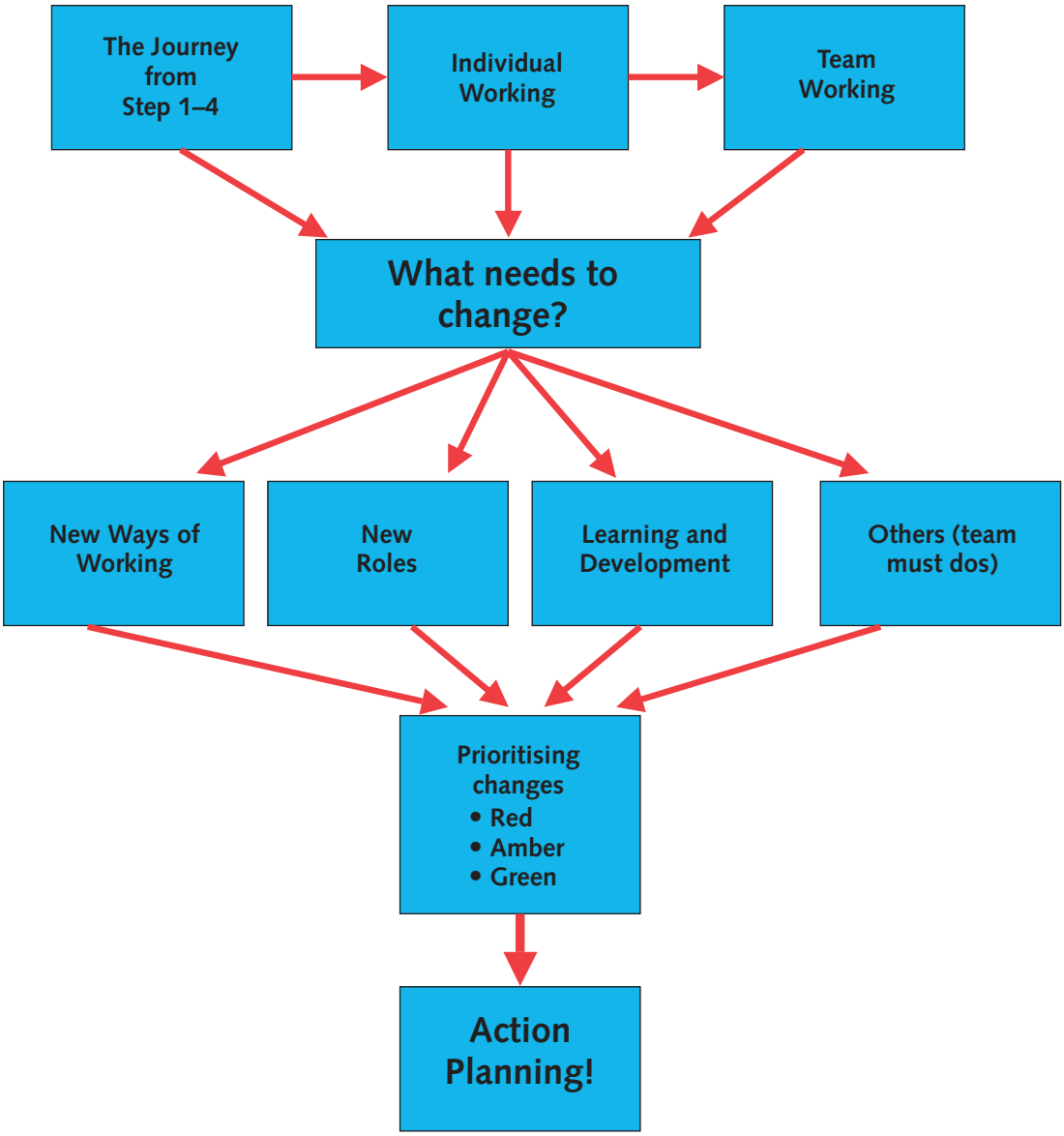
What advice would you give about how the workshop could be run better?

Step 4:
Creating A Needs Led Workforce

CONTENTS

Step 4: Creating A Needs Led Workforce (workshop 3)

Workshop Pathway



Step 4:
Creating A Needs Led Workforce

PARTICIPANT'S PROGRAMME

Aims of the day

The aims of step 4 are to:

- Reflect on, and bring together all the information and outputs from all previous sessions
- To consider options for change based on the information gathered throughout the process taking into consideration
  - New Ways of Working
  - New Roles
  - Learning and Development (including unused skills)
- Other (team must dos)
- To discuss and consider the implications of each option for change and identify changes that the team can implement and changes that require SMT approval
- To agree preferred options and develop and complete team profile and workforce plan (to include action plans)

NB: The team leader should take a major leadership role in this workshop

9.15	**Arrival and beverages**	
9.30	**SESSION 1 – Introduction to Step 4**	
	The Facilitator and Team Leader will remind the team of the journey from Step 1–4 reflecting key issues, areas of difficulty and positive achievements using the team profile and workforce plan as a framework Identify buddies for absent team members	**Team profile and workforce plan** **2. Buddy record**
10.15	**SESSION 2 – What needs to change (A-B)**	
	Part A – Identifying changes Using your completed individual profile and working differently sheet transfer all your suggested changes onto individual Post-its and post onto one of the 4 flip charts entitled: • NWW • New Roles • Learning and Development • Other (team must dos) **Output from Part A – 4 flip charts identifying changes under the four headings** **Part B – Team capability profile** Chart the information recorded on your individual capability onto the team capability profile flip chart Split into 4 groups and reflecting on the results charted identify • **Capabilities not held by anyone** • **Capabilities held by majority of the team** • **Capabilities that people have but don't use** Identify any changes that need to occur to ensure team members have the capabilities and competences to meet the priority needs eg: • **Learning and Development (this can be formal or informal i.e. shadowing mentoring)** • **Unused skills** • **Skills that could be shared with others** Feedback as a group and write your changes onto individual Post-its and post onto one of the 4 flip charts (NWW, NR, L&D, Other) from Part A **Output from Part B – Flip chart which provides an overview of the existing competences and capabilities within the team and where the gaps are**	**Individual** **Profile (from step 3)** **Working differently sheet (from step 3)** **3. Team Capability profile**
11.15	**BREAK**	

11.30	SESSION 2 – What needs to change (C–D)	
	Part C – Prioritising changes Remain in your 4 groups and you will be given one of the 4 flip charts (NWW, NR, L&D, Other) Prioritise the changes into: • **Red = Long term complex changes/require SMT approval** • **Amber = Changes over time/achieved through reallocation of resources** • **Green = Quick/easy changes/can be achieved by the team** When completed, as a group, move around the flip charts so that each group has an opportunity to look at all 4 flip charts to see if they agree with the other groups, if not place a Post-it next to the change stating the reason why you disagree **Outputs from session – 4 flip charts with changes arranged in red, amber and green positions that the whole team agree with** **Part D – Priority changes** The facilitator will place 3 flip charts on the wall entitled red, green and amber. Each group will now be required to write their changes onto the appropriate flip chart **Output from Part D – 3 flip charts listing Red, Amber and Green Changes**	
12.15	**LUNCH – During lunch you may wish to think of a question you would like to put to the whole team as part of Session 5**	

1.00	SESSION 3 – Action Planning	
	Part A – Red changes Each team member will be given 2 red stickers which you should place next to the 2 red changes you feel are priority The two top changes will be identified as those with the most red stickers. If any changes have an equal amount of stickers you will be allocated 1 red sticker and undertake the exercise again with those changes If a consensus still cannot be reached the team leader will have the final say in prioritising the 2 changes to be taken forward to SMT, however the others will not be lost and will be recorded in the team profile and workforce plan You will then be required to record the remaining red changes on the red action plan and be given time to discuss, agree and record proposals for addressing these in the short and long term **Output from session – Action plan for red changes** **Part B – Action planning** Divide into 2 groups and you will be allocated one of the 2 agreed red changes to be taken to SMT As a group debate the change and flip chart suggestions and ideas for achieving it Return to the larger group and feedback your thoughts and as a team produce an action plan identifying: • **The change** • **Proposals/suggestion/actions required to achieve the change** • **Proposed timescales for implementing the change** • **Person leading/taking responsibility for the change** • **Agree timescales for presenting to SMT and feeding back to the team** **Output from session – Action plan for SMT approval** **Part C – Amber changes** Split into 3 groups and the facilitator will allocate you a number of amber changes As a group discuss and make suggestions/proposals for how these changes could be achieved and produce an action plan which identifies • **The change** • **The action required** • **By whom and by when** • **Resources required** **Output from session – Action plan for amber changes**	**4. Actions plans** **NWW and New Roles (from Step 1)**

	Part D – Green changes As a group consider the information on the Green changes flip chart from session 2 and identify any quick wins that can be achieved by the team and produce an action plan identifying • **The change** • **The action required** • **By whom and by when** • **Resources required** **Output from session – Action plan for green changes** **Part E – Keeping the actions alive** As a whole team, identify any barriers to achieving and sustaining the changes and feedback to the facilitator who will record them on a flip chart The barriers will be then shared equally between 4 groups Each group should agree actions to overcome the barriers and sustain the changes and feedback to the facilitator If you have not already done so, the whole team should agree: • A 3-monthly, 6-monthly and 12-monthly review date to include all those who have participated in the process • That the action plan is a regular agenda item at the team meeting (frequency and meeting to be determined by the team) • A communication strategy for ensuring that those who are not daily team members continue to be updated and consulted about the implementation of the actions	
3.00	**BREAK**	
3.15	**Session 4 – Summary of Step 1–4**	
	The facilitator will draw the workshops to a close by reflecting on the journey the team have taken from steps 1–4 and where they are hoping to go This process will be guided by • **The completed team profile and workforce plan** • **Red, amber and green changes** • **Red, amber and green action plans** The facilitator will allow time for the team to discuss their thoughts and feeling about the process and their anxieties and concerns about taking the actions forward. Any final agreements or suggestions made to support the process should be recorded with a lead person identified	

3.30	**Session 5 – Vote with your feet**	
	There will be 3 sheets entitled Yes, No, Not sure each placed in a corner of the room You will be asked a number of questions and requested to stand in the area that matches your response. The facilitator will ask people to share with the group their reasons for choosing to stand in a certain area You may also wish to ask your team members a question. If so this will be done in the same way as above	
3.50	**Session 6 – Evaluations and questionnaire**	
	The facilitator should ask each team member to complete the participant's evaluation and the post workshop questionnaire allowing time for reflection and closure of the day	**5. Post workshop questionnaire** **6. Participant's evaluation form**
4.00	**FINISH AND COFFEE**	

STEP 4: CREATING A NEEDS LED WORKFORCE – HANDOUT 2

BUDDY RECORD

If a team member is unable to be present at a meeting/workshop a buddy should be identified and their name recorded. It will be the buddy's responsibility to ensure all information, including handouts, is fed back to the absent team member. This information should be recorded below.

Absent team member	Buddy

STEP 4: CREATING A NEEDS LED WORKFORCE TEAM CAPABILITIES PROFILE – HANDOUT 3

Change/staff initials																					
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
7.																					
8.																					
9.																					
10.																					
11.																					
12.																					
13.																					
14.																					
15.																					
16.																					
17.																					
18.																					
19.																					
20.																					

✓ = Have and need X = Don't have and don't need N = Need but don't have H = Have but don't use
C = Could do in the future D = Need to develop/improve

STEP 4: CREATING A NEEDS LED WORKFORCE – HANDOUT 4

Action Plan

Green changes	By whom	By when	Resources required

STEP 4: CREATING A NEEDS LED WORKFORCE – HANDOUT 4

Action Plan

Amber changes	By whom	By when	Resources required

STEP 4: CREATING A NEEDS LED WORKFORCE – HANDOUT 4

Action Plan

Red Changes

Aim (what)	Objectives (how)	Lead Responsibility (who)	Target Date (when)	Resources required
1.				
2.				

Step 4: CREATING A NEEDS LED WORKFORCE – HANDOUT 5

POST-WORKSHOP QUESTIONNAIRE

This questionnaire is designed to provide information to help us to identify your needs and refine the CCTA approach further. Please compete the questionnaire after completing all 3 workshops and return to the CCTA facilitator prior to leaving the last workshop (Step 4)

Role		
Service Area (CAMHS, In-patient etc)		
Type of Organisation (NHS/Voluntary Sector etc)		
Which Steps did you complete?	✓	**Reason for not completing**
Step 1 – Preparation and ownership		
Step 2 – Team function		
Step 3 – Service user and carer needs		
Step 4 – Creating a needs led workforce		
Step 5 – Implementation and review		

For each of the following statements, please indicate how true it is for you, using the following scale:
1 = Not true at all 2 = May be true 3 = True 4 = Very true

A	Participation and Choice	Score
1	I enjoyed completing the CCTA	
2	The CCTA workshops were fun to do	
3	The CCTA process was about the right length of time	
4	I believe I had some choice about doing this activity	
5	I believe the CCTA was of some value to me	
6	I did the CCTA because I wanted to	
7	I think myself, and the team, benefited from undertaking the CCTA	
8	I will be willing to undertake ongoing work to support the implementation of the CCTA action plans because they have some value to me	
	(Maximum Score 32) Section A Score	

B	Preparation	
9	I feel I was well prepared for undertaking the CCTA	
10	I feel that the all the team members had a good understanding of the CCTA process prior to commencing the workshops	
11	I feel that the organisation supported the CCTA process and had a good understanding of their role within it	
	(Maximum Score 12) Section B Score	
C	**Outcomes**	
12	I feel I am able to apply the principles of NWW and New Roles well within the team	
13	I think the SMT will support the actions identified	
14	I think the team is capable of implementing the actions for change identified during the CCTA process	
15	I feel confident about my knowledge and understanding of NWW and New Roles	
16	I have a good knowledge about the local population the team serves	
17	I feel I have a good knowledge and understanding about the needs of the service users and carers the team serves	
18	I think that the CCTA was important because it will improve services for service users and carers	
19	I think that doing the CCTA was useful for improving my practice and that of the team as a whole	
20	I have a good understanding about the skills, knowledge and experience within the team	
21	I feel that the CCTA will improve the workforce planning process within the organisation	
	(Maximum Score 40) Score from Section C	
	Total Score from Section B	
	Total Score from Section A	
	(Maximum potential score 84) Overall total score from A, B and C	

Additional information Are there any other comments/learning experiences you would share about the CCTA?
Date Completed

STEP 4: CREATING A NEEDS LED WORKFORCE – HANDOUT 6

PARTICIPANT'S EVALUATION FORM

Please rate each session, indicating the extent to which you found each relevant and useful, and how well it was run

1 = not relevant/useful 5 = extremely relevant/useful

1 = did not run well 5 = ran extremely well

SESSION 1 – Introduction and Reflection					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 2 – Prioritising Changes					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 3 – Action Planning					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 4 – Summary of Step 4					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

SESSION 5 – Vote with your feet					
Relevance/usefulness	1	2	3	4	5
How well the session ran	1	2	3	4	5

The best things about the day were:

The least satisfactory things about the day were:

What advice would you give about how the workshop could be run better?

Post-Workshops

Step 5: Implementation and Review

CONTENTS

Step 5: Implementation and Review

Aims

The aims of step 5 can be achieved at pre-existing SMT and team meetings, the duration and frequency of which will differ within each organisation. However, it is crucial that this step is completed to enable the outcome of the CCTA to be actioned and sustained appropriately.

Meeting with the Senior Management Team

The aim of this meeting is to:

- Present the SMT with the team profile and workforce plan which will incorporate:
  - Overview of key themes that have arisen during the CCTA process
  - The journey the team have taken
  - The team action plans (including all red, green and amber actions)
  - Outcomes from the pre and post questionnaires (presentation)
- Highlight and agree options for change that require SMT approval and resource allocation
- Present and discuss the team's proposals for implementation
- Agree an implementation process and an effective communication strategy
- Identify how the workforce planning summary and the team profile and workforce plan can inform the organisation's workforce planning process
- Identify mechanisms to sustain any changes

To achieve the aims it may be appropriate for this meeting to be attended by the senior sponsor, facilitator or team leader depending on the structure of the organisation and their contribution and participation in the process.

Whilst the workforce planning summary will provide the SMT with a brief overview of the issues identified and the proposals for change, the team profile and workforce plan provides detailed information about the team's journey through the CCTA process and the evidence to support the suggested changes. It will also allow the SMT to make an informed decision about the options for change taking into consideration the organisation's workforce strategy

and national and local drivers. This process may take a number of meetings; however, once a decision has been made the team should be informed formally about the outcome and the rationale behind it.

The team should then be involved in the development of a plan to support implementation of the agreed change.

Meeting with the team

Once a decision has been reached by the SMT the facilitator should meet with the team, ideally at a regular team meeting, to:

- Ensure each team member has received an electronic copy of the team profile and workforce plan
- Hand over the implementation process to the team
- Discuss the development of a plan to support the implementation of the change
- Present and discuss the outcomes of the pre and post workshop questionnaire.

Certificate

In recognition of the team's hard work and successful completion of the CCTA the facilitator and the senior sponsor should sign the CCTA certificate and present to the team.

Review

It is essential that the team receives support from the senior sponsor during the implementation phase. Continued support from the facilitator will need to be negotiated and will depend on their capacity, however, they may be able to offer arm's length support or attend review meetings if necessary.

The implementation plan should clearly identify regular meetings between all parties together with on going arm's length support from appropriate individual or service areas. This can also be used as an opportunity to produce an update report for SMT. As suggested in Step 4 the team should pre arrange 3-monthly, 6-monthly and 12-monthly review meetings for all who participated in the process.

The team should use the team profile and workforce plan as a working document and consider undertaking key aspects of the CCTA again at a later date, in particular Steps 3 and 4 which will help the team assess what they have achieved.

STEP 5: IMPLEMENTATION AND REVIEW – HANDOUT 1

WORKFORCE PLANNING SUMMARY

Whilst undertaking the CCTA process the team have gathered a wealth of information about the team, the staffing, the needs of the service users and carers and the skills and capabilities required to meet those needs. All of this information is recorded in the Team Profile and Workforce Plan (TPWP) which captures the team journey throughout the CCTA providing the underpinning evidence to support the suggested changes.

The workforce planning summary is not intended to replace the TPWP but aims to provide a very brief overview of the outcomes.

Team	
Base	
Team's agreed establishment	
Current vacancies within the team	

The team's current staffing		
Role	**Band/level**	**Number of staff**

Key issues identified	Proposal to address the issue (New Roles, NWW, Learning and Development)

This information will inform the organisation's workforce planning process. For further information, supporting evidence and action plans please refer to the Team Profile and Workforce Plan.

For further guidance on workforce planning please see: *Workforce Design and Development: Report on the NIMHE National Workforce Planning Pilot Programme (WPPP) Best Practice – Main Report* (DH 2006).

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