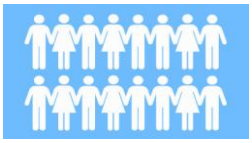
Capable Teams for Children & Young People (CTCYP): Team Profile and Workforce Plan

Example 4
Tier 4
December 09 – July 10

STEP 1 – PREPARATION & OWNERSHIP

STEP 2 – TEAM FUNCTION

STEP 3 – CHILDREN, YOUNG PEOPLE, FAMILIES & CARERS



STEP 4 – CREATING A NEEDS LED WORKFORCE

STEP 5 – IMPLEMENTATION & REVIEW

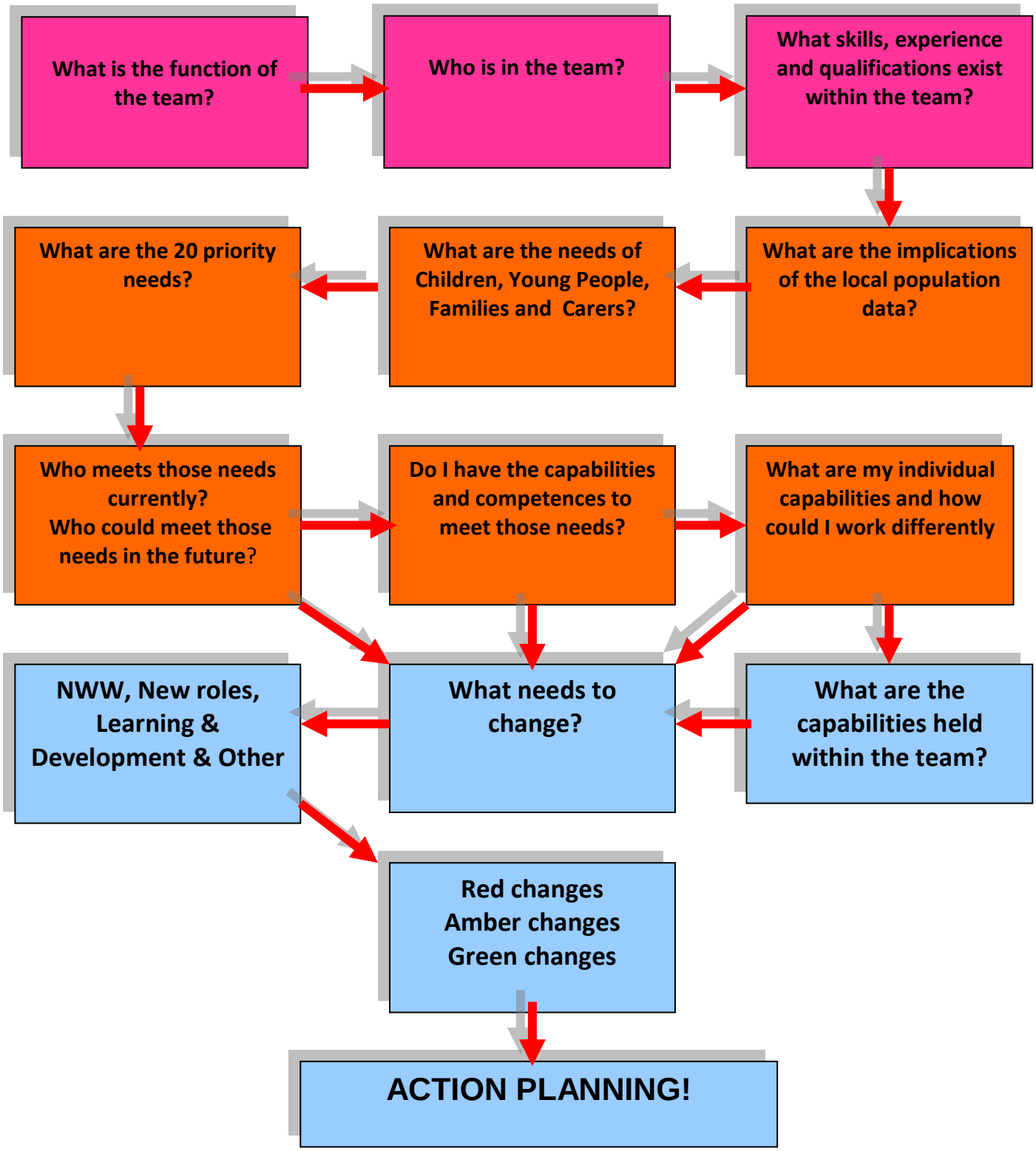
Please note this is an original TPWP developed by a Tier 4 CAMHS Team as part of the CTCYP National Development and Implementation Programme

CAPABLE TEAMS FOR CHILDREN AND YOUNG PEO0PLE (CTCYP)

TEAM PROFILE AND WORKFORCE PLAN

Team	**Tier 4**	
Base		
Team Leader		
Senior Sponsor	**Associate Director of CAMHS**	
Facilitators	**Nicki Hollingsworth** **Val Lake**	
Date commenced CTCYP	**December 2009**	
Date completed CTCYP	**July 2010**	

Workshop pathway



STEP 1: PREPARATION AND OWNERSHIP

Name and one non- work related skill

Tim – Good at drawing
Lorraine - Cooking
Jim – to be undressed!!
Karen – sign language
Kelly – Netball for Colchester United
Debbie – irons for people
Dave – golf
Nigel – water scuba diver
Kevin – Annoying people
Linsey – speaks Spanish
Lizzy – photography
Toni – patchwork quilts
Paula – advanced motor cycle
Gill – chair of parish council
Deborah – climbing in north Wales
Matthew – political campaigning

What does NWW mean to you?

- Expanding roles in creative ways
- Different ways of communicating
- Making more use of feedback, from all stakeholders
- More posts and more training
- How do we avoid splitting in order to bridge gaps
- How do we alleviate and address anxiety brought about by these changes
- Creative ways of using resources i.e. skills already within team
- Innovative – doing things differently
- Responsive – client population
- Creating services that respond to those young people with greatest need
- Thinking about bigger picture- staff, young people, service development
- Will require us to look at how we respond now
- Don't throw baby out the bath water
- Ability to identify which parts of our current service work and which parts don't
- Be prepared to receive feedback from children, young people, families and carers and make full use of this for planning and strategic work.

Why do you think NWW are needed?

- To meet changing needs
- To create better service
- Job satisfaction
- Service user and stakeholder satisfaction
- To survive, we need to be ahead of the game
- To enable and ensure use of growing evidence base
- To demonstrate to partners we are partners and encourage sharing skills, practice etc.
- On going training to develop new skills
- To promote motivation of staff to: be consistent and clear about current best practice and to be prepared for change that should improve practice.

Examples of local New roles and NWW

- Crisis team experience
- Psychologist / trainees
- Ward clerk
- More HCA's
- New Psychotherapist
- Colour coding mops, gloves, clothes
- New Service manager
- Ward manager
- Occupational therapist
- House keeper
- Psychiatrist
- ST3 / someone with stethoscope
- Supervisor for support services
- CAMHS Director (or something)
- RAPP, SAIF
- Twilight timings
- No overtime
- Bank
- Emergency assessment slots
- 24hr access
- Clinician of the Day
- NETSS
- Crisis Outreach model
- Clinical Outcome Measures
- Managing specific client groups e.g. eating disorders, ADHD
- Assessment process
- Behaviour Nurse Therapists
- 'Host' for other services
- Consultant Nurse posts
- Associate Practitioners
- Band 5 – rotational post
- Psychology assistants
- Family Therapist in core team
- Forensic Psychology
- Staff seconded to other agencies
- Director of Business planning
- Associate directors of nursing
- Modern Matrons
- Associate Director of Psychological therapies
- Pharmacy technicians
- Head for learning disabilities (Trust wide)
- Teaching staff offering Psychotherapy
- Systemic practitioner which is like (apprenticeship type) family therapy
- Expanding on roles i.e. RAP group, activities coordinator, behaviour support work expanding to instructor role
- Responsible clinician instead of RMO
- Learning and developing roles from in-house staff
- Expansion of Outreach

Barriers to involving children, young people, families and carers

- Mental health – possibly not a current client
- Young person being daunted by being part of this
- Don't want to make someone special
- School attendance
- Need a balance- don't want to take advantage of goodwill
- It is a big commitment for someone who is working
- Do we chose or ask for volunteers?
- Capabilities. Able. Prepared
- Availability
- Token gesture/representation (also on our part/defensive
- Current v past clients
- Choice of who to ask
- Confidentiality
- Parental consent
- Families or individuals
- How will staff manage/feel with regard to staff issues/dynamics
- Practicalities: accessing groups, meetings etc
- Lack of crèche facilities
- Feeling intimidated

Solutions to involving children, young people, families and carers

- Clear expectations of what is needed
- Generic call for expression of interest
- Make it worth their while
- Named responsible person

- Communication
- Flexibility of meetings/timings
- Past ideas regarding involving service users – shift in thinking is needed
- Time, motivation, health, stigma
- Regular open day to provide info and recruit existing or potential service users/carers or other interested parties
- Avoid jargon
- RAPP groups
- Use of Witnesses
- Use of pool of involved people, so share the work.
- Be clear about advocacy services
- Improve existing young peoples forum
- Involve other services i.e. trainees, students, 6th forms, Connexions

Plan of Action to involve children, young people, families and carers

- Develop and send out generic letter
- Target existing and past service users
- 3 users and 3 carers
- Involve Suzanne Free (Advocate)
- Identify payment policy for reimbursement and payment
- To be led by Gill and Tim

STEP 2: TEAM FUNCTION

What does the ESC assessment tell us and what do we do/could do to improve how we address the ESC?

Challenging Inequality

- Unconscious expectations and attitudes of the client group.
- Do our observations and feelings have an effect on the treatment and future outcome of the client?
- Limited Resources - challenge broader inequality done at clinical level within resources available and within direct control.
- easy in Comm. 'Dispel the Myth' reducing stigma campaign – T4
- **More promotion and awareness i.e. RAPP group – kids group – discussion/debates/stigma.**
- Returning to wider community – how they promote themselves and choose to promote themselves.
- **Nurses to join/contribute to PSHE/Youth awareness with education department.**

Personal Development

- Some ambiguity over training needs IPR – KSF and what is required of staff in finding adequate supervision etc

Respecting diversity/working in partnership.

- **More promotion and awareness i.e. RAPP group – kids group – discussion/debates/stigma.**
- Returning to wider community – how they promote themselves and choose to promote themselves.
- **Nurses to join/contribute to PSHE/Youth awareness with education department.**

- Feeling amongst group 1 is that we are poor at this.

Providing service user centred care.

- Culture of managing supersedes the culture of collaboration

Identifying people's needs/strengths

- Need to be more focused, strength and disparity between young people's views of their needs and teams' view of young peoples needs. (Balance between problem and strength). E.g. social care needs.
- Avoidance of young person of challenges e.g. need for education
- **Social care deficit – link worker (CP) to T4**
- **Proposal for SW in Crisis Outreach and T4 skill mix**

Promote Recovery/Intensive Transition (CO) – T3

- Social Inclusion
- Partnership working

Reflections on process

- Greatest variance in team and Individual
- How useful is self assessment tool alone.
- Team and individual reflective capacity/capability.

NATIONAL AND LOCAL CONTEXT

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

Presentation removed for confidentially purposes

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

- **Housekeeper** – benefits young people/meets national requirements/infection control/ECM
- Structure – revamp CPA/CMM/Review processes and requirements. Efficient, avoid duplication
- Program – motivational therapy/work. Motivational speakers
- Role – parent advocate. Education community link or work
- Program to adjust for non-mandatory education aged YIPS? Role e.g. job coach, in-reach connections group focused and intensity
- Role – advanced practitioner role into service
- Program – groups with MDT – portfolio of interests. Also backed up with training and supervision e.g. CBT/ACE
- Daily MDT meeting/consistency/communication/decision making
- Re: thinking roles e.g. best practice. Roles using evidence and ensuring implementation. Nurses – specialism e.g. Psychosis.
- Close working with medics re: medication/psychological therapy
- Housekeeper – expand role to support social skills, personal hygiene and nutrition
- Flexible/rotating posts. Opportunity to move around organisation (but maintain stability) all team
- More emphasis on families/systems. More intensive and variety of approaches/locations

- Benefits: Creative, strategic, relative, reputation.
- Responsible clinician and nurse prescribers
- Help eliminate some of the problems seeking medical opinion for section 17 leave etc. New model of working i.e. AMHP's
- Imbalance in staff team. Not enough middle qualified staff i.e. therapists.
- Re: think qualifications – think outside of the box in developing roles i.e. therapists/occupational therapists.
- Family therapy suite
- CAMHS Glossy brochures
- Crisis Outreach Bus (timetable)
- Crisis line i.e. Neril
- Crisis cards
- Training/Supervision
- Age appropriateness
- Eating disorder specialist/Nurses Learning Disabilities specialist
- MDT daily presence
- Nurse

The team		
Name (A)	**Role (B)**	**Number of Years' Experience**
Deleted	Teacher	21
Deleted	Teacher	25
Deleted	Senior Health Care Assistant	1
Deleted	Charge Nurse	16
Deleted	Support Services Assistant	1
Deleted	Head of Education	20
Deleted	Charge Nurse	18
Deleted	Senior Health Care Assistant	7
Deleted	Unit Administrator	6
Deleted	Consultant Clinical Psychologist	15
Deleted	Senior Health Care Assistant	3 ½
Deleted	Forensic Clinical Nurse Specialist	12
Deleted	Acute Services Manager	15
Deleted	Senior Health Care Assistant	5
Deleted	Behavior Support Worker - Education	3 ½
Deleted	Staff Nurse	2
Deleted	Clinical Manager	23
Deleted	Staff Nurse	20
Deleted	Senior Health Care Assistant	2months

Deleted	Senior Social Work Practitioner	30
Deleted	Medical Secretary	18
	Total number of years	**323**

Existing skills, knowledge and experience within the team

- Therapeutic communities**.**
- Managing residential establishments.
- Mainstream school curriculum
- Young people with challenging behaviour.
- 9yrs teaching in local school
- Dressing skills with leukaemia and diabetes.
- Good skills engaging with young people.
- Children with EBD, ASD.
- Teaching at Essex Uni. Neuro developmental disorders.
- Supervising – managing group programme.
- Lead for Tier 4 Psychology services in North Essex.
- L.D/PCP.
- Female personality disorder in probation sector.
- Detained MHA.
- DSI and violence.
- Problem solving.
- Low secure unit.
- Criminal justice Team/ YOT.
- Adult acute services.
- Setting up Com team in Suffolk.
- Assertive Outreach.
- Speciality acute psychosis.
- CBT and solution focus therapy.
- Exp of Adults/Older and CAMHS, in-patient and community.
- BSc specialist practitioner.
- Project management.
- Leadership skills.
- Change agent.
- Mental illness/Medication.
- PALS lead.
- Adult rehabilitation.
- Community Adult.
- Managerial skills.
- Exp as Psychiatric nurse in Emergency dept.
- Head of faculty – management.
- Severe autism exp.
- Close family liaison.

- **Existing qualifications**
- Diploma in social work
- Diploma in Art and design
- Team Management
- Supervisor Skills
- Individual counselling
- Mini bus licence
- City & Guilds in learning support
- advanced Certificate in learning support
- ASDA tutor/moderator
- Clait marking course
- Food hygiene.
- C&R.+
- Qualified teacher in P.E. English, Drama.
- Diploma in special Educational needs.
- Qualified therapist with Masters
- Degree and post grad teaching.
- Key Teacher at <<<<<<<<.
- Eating disorder practitioner course.
- BSc Hon / Master Degree in Psychology.
- Research methods.
- Doctorate in clinical psychology.
- Diploma in leadership & management.
- Masters degree in child And adolescent forensic psychology
- Foundation degree in therapeutic communication and organisation.
- Care assessment in children's hospice.
- NVQ in Health and Social care.
- RMN.
- BSc Forensic care studies.
- Dip in mental health nursing.
- Hon specialist practice mental health nursing.
- MSc in mental health.

- Psycho analytical MSc.
- Symbolic play counselling course.
- ECDL.
- Diploma in sport psychology.
- Health and Safety.
- COSHH.
- Infection Control.
- Breakaway.
- Degree in Philosophy.
- Trampoline Instructor.

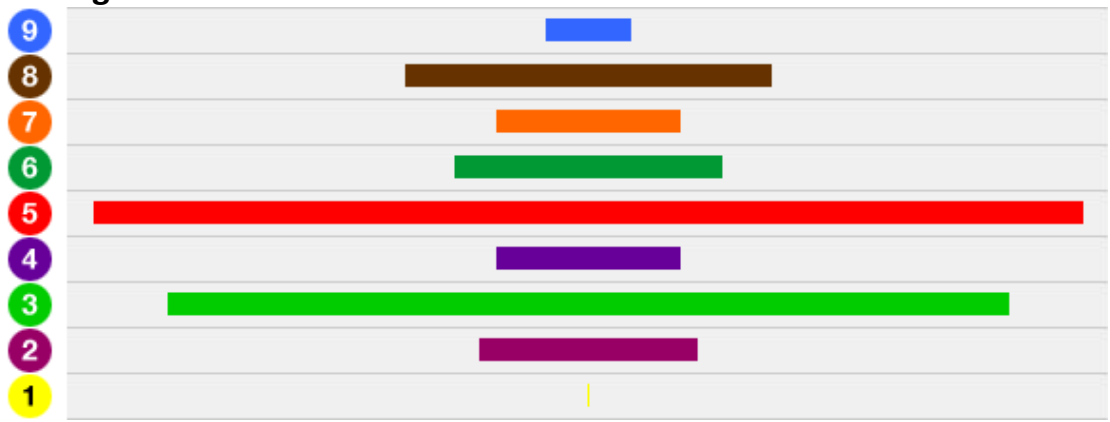
Skills and knowledge to develop

- Becoming an art therapist.
- Understanding of adolescent mental health.
- Education team to meet needs of new unit.
- More responsibility,
- Career development.
- Continue to develop interest and training in Forensic Psychology.
- Counselling.
- Clinical practice.
- Group Skills training/CBT.
- Public speaking.
- Patient safety.
- Delegation skills.
- Advanced ECDL.
- Supervisor/housekeeper skills.
- Eating disorder qualification.
- Autistic spectrum.
- IT skills.

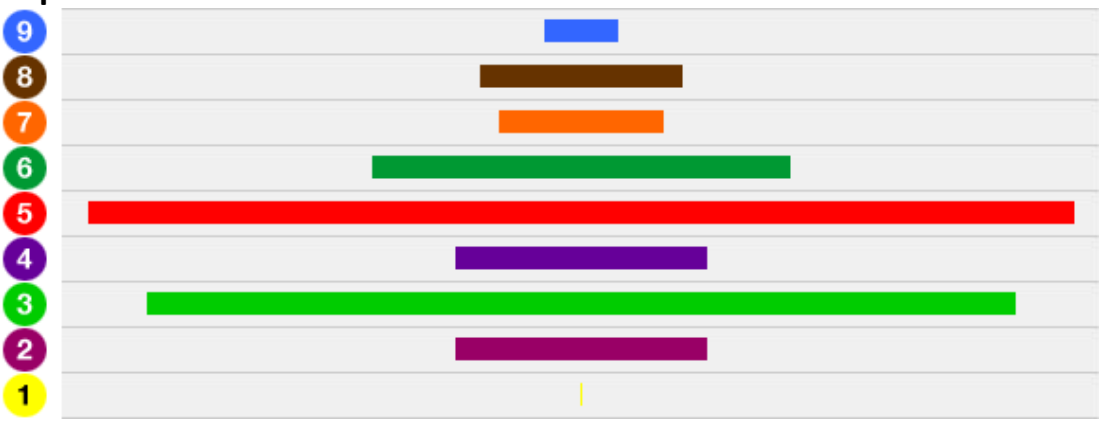
The team staffing	
The teams' current establishment?	**Health** • 1 WTE Consultant Psychiatrist 0.4 WTE AMD role • 1 WTE Acute Service Manager/Matron 8B • 1 WTE Clinical Manager currently 8A , proposed B7 Ward Manager • 1 WTE Consultant Clinical Psychologist 8C with 0.4 allocated Forensic/Youth offending lead & Crisis O/R • 1 WTE Consultant Systemic therapist/Professional advisor role • 1 WTE Senior Social Worker B7 • 1 WTE Psychology assistant • 3 WTE Charge Nurses, B6 • 9.8 WTE funded Staff Nurses B5 (2 Vacant) • 8.8 WTE funded SHCA B3 (0.8 vacant) • 1 WTE Team Administrator B5 • 1 WTE Medical secretary B4 • 0.5 WTE Ward Clerk B3 • 2.5 WTE Support services (0.5) vacant **Education** • 1 WTE Head of Education • 2 WTE Teachers • 1 WTE Behaviour support worker • 0.6 WTE Administrator
What number of vacancies currently exists within the team?	• 2 WTE funded Staff Nurses B5 • 0.8 WTE funded SHCA B3 • 0.5 WTE Support services

Proposed draft staff establishment Tier 4 re-provision - Health	**Medical** • 2 WTE Consultant Psychiatry • 1 WTE ST 4-6 • 1 WTE ST 1-3 **LSU Nursing** • 1 WTE Band 7 • 2.78 WTE Band 6 • 11.68 WTE Band 5 • 7.90 WTE Band 3
Proposed Tier 4 Staffing re-provision - Health	• 1 WTE Band 7 • 4.41 WTE Band 6 • 10.22 WTE Band 5 • 10.45 WTE Band 3 **Admin/support staff** • 1 WTE Team administrator Band 5 • 2 WTE Admin Band 4 • 1.5 WTE Admin Band 3 • 1 WTE Support service supervisor Band 3 • 5.8 WTE Support services Band 2
Proposed Establishment Education Tier 4	• 1 WTE Head of Education & 1 WTE Admin **Low secure** • 2 WTE Teachers • 1 WTE Behaviour support worker **Generic** • 3 WTE Teachers • 1 WTE Teacher (job share) • 1 WTE Behaviour support worker • 1 WTE School engagement mentor (Band 4) •

Existing health funded establishment



Proposed establishment health and social care



Implications of Team Staffing

- Use Band 6 'floater' to free up nursing skills – releasing time to care.
- Training SHCA's to fill vacancies
- Nurse specialism to fill gaps and develop new roles (cost effective)
- Housekeeper (band 3) – How to use vacancy
- Currently no career progression for nurses within team - career ladder (band 4)
- Specialists – band 6/7 – enable career progression.
- New Unit may enable greater career progression – rotation
- Training
- Dietician – with wider service
- A gap still exists in band 8 psychology
- Psychiatry and family therapy
- Have a community liaison/activity worker to work against stigma and to maintain links with the community (normalisation)
- STR posts (Support Time Recovery)
- Gaps for Occupation Therapy
- Actively offer opportunities to **ALL** staff who wish to develop and progress
- Admin
- Art therapist
- Charge Nurses? T3/T4
- Good Career Ladder – Secondments
- Cost – expensive (specialist
- More joint working – learn form each other
- Transparent diaries – shifty
- Good education model
- Forensic Training
- Group work co-ordinator
- Education – no career pathway
- Nursing 3/4/5 6? 7?

- Shift work for all
- Develop roles/ systemic family therapist/MDT/Specialist nursing
- Is the secure unit secure given that level of need of clients requiring a lot more support therefore higher staff input, higher obs levels
- Who knows if staffing is cost effective? How much is a bed? Running cost of unit food, electric, repairs, laundry, backfill, and therapist.

The team statement

To provide tailored, needs led Community outreach and inpatient specialist mental health care and treatment to young people, their families and carers Within an age range of: 11-18 for inpatient for care and 5-18 for community care in the area of Essex and Eastern region 24 hours a day, 7 days a week

The team's primary functions

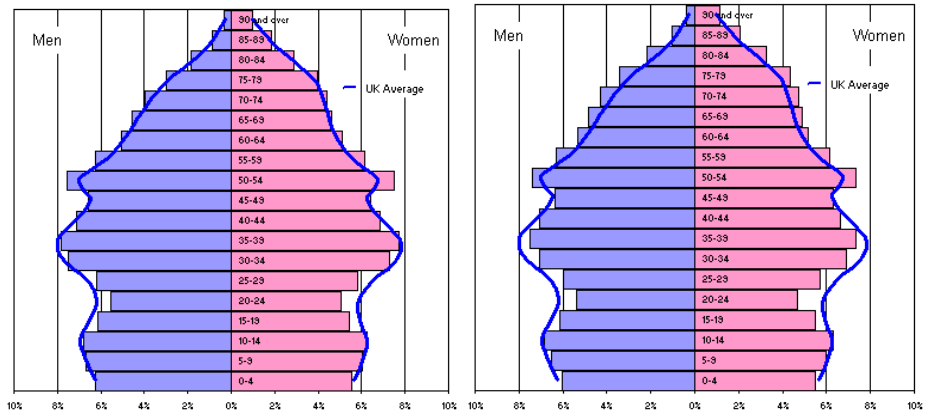
- Assessment, treatment and consultation in least restrictive therapeutic environment
- Support and maintain the safety of young people in our care
- Collaboration with all involved
- To create positive outcomes
- Provide teaching, training and education
- Transitional care
- Care package reviews
- To provide reassurance and hope
- Containment

The team's 5 core values

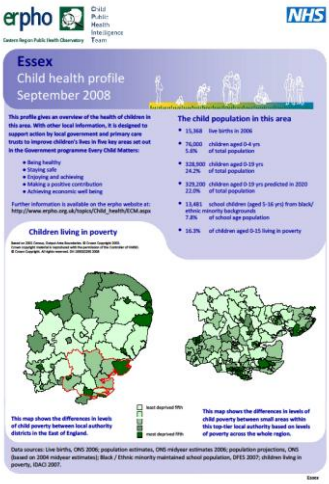
- Dignity
- Respect
- Equality and diversity
- Inclusion and collaboration
- Compassion
- Evaluate and improve quality of care
- Shared ethnical values
- Needs Led

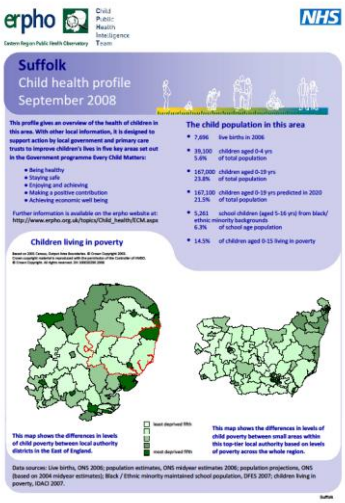
STEP 3: CHILDREN, YOUNG PEOPLE, FAMILIES AND CARERS NEEDS

THE LOCAL POPULATION

Demographic information	
What population does the team cover?	 Essex – 131, 0835 total pop Suffolk = 66,855 total pop
What is the age profile of the population?	Essex 328, 000 age 0-19 = 24.2% of population Suffolk 167,000 children 0-19 = 23.8% of population
What is the male/female split?	See above charts
What is the ethnicity profile of the population?	Essex – 13,481 (age 5-16) from BME backgrounds = 7.8% Suffolk - 5,261 (age 5-16) from BME backgrounds = 6.3%
Is the area covered rural, urban or coastal?	

Click on pages below to see full child health profiles for Essex and Suffolk





Impact of the local population data

Population size

- Figures suggest population increase is not too significant, however, use of Olympic buildings and houses being build near Severalls site and local area
- New sports centre in Harlow
- Tendring – coast academy – counsellors – pastoral
- New build increase population – demand and housing association
- SH East - West

Geography

- Diverse and graphically spread area
- Secure service – accessed by young people from out of area with no knowledge of the local services/family members – implications for visiting.

Employment status

- New government
- Employment and education – increase in NEET's concern

Male/female split

- Continue to see more females than males

Local intelligence/trends

- Suffolk figures for drug and alcohol misuse worrying but relative to what we know. More community services needed.
- Methadrome – legislation
- Essex DAT = dual diagnosis – impact on Crisis Outreach

NEEDS OF CHILDREN, YOUNG PEOPLE, FAMILIES AND CARERS

The Green Needs of children, young people, families and carers

- Parent Advocacy and more young people advocacy
- More access to complimentary therapies so patients can self soothe
- Education around specific conditions
- Smoking cessation substance misuse
- More information on individual conditions
- Carers, access to different employment options
- Staff within general hospitals to have a better understanding and tolerance of young people and nursing staff when on A&E wards
- Supportive
- Encouraged to enable own choices and help with where to go

The Amber Needs of children, young people, families and carers

- Informative information i.e. leaflets, brochures
- Transport, major need given geography
- Nurse prescribing to relieve work for unit doctor
- Mentoring system for rehabilitation
- Needs led therapeutic intervention
- Need to educate teachers in mental health needs for young people
- Schools are the country's largest mental health institutions yet teachers are not always confident in addressing young peoples mental health needs
- Holistic approach – whole family
- Carers, tailoring individual to therapists.

- Carers, core teams in CPA's

The Red Needs of children, young people, families and carers

- Respect
- To be received by an institution that has a common therapeutic role/identity
- Choice of appropriate treatment
- No tokenism
- Therapeutic respite
- Respite as a complimentary
- Specialist trained nurses i.e. Eating disorder specialist, diabetes, CBT
- Discharge planning
- More training for nurses i.e. CBT
- Safe, Modern comfortable environment
- An environment suitable for young people, better facilities
- Coping ideas from Summerhill school- visa a vie young people
- Groups focusing on independent living skills as not al young people are discharged to their home
- Need for SHO full time on the Unit
- Minor physical health needs to be met on the Unit rather than going to home GP
- Carers, Know who to contact and easy access and approachable i.e. email, text etc
- Carers, Reassurance
- Social Inclusion. Enabling service users from all backgrounds t get the best from the service
- Equality
- Carers, to have access to advocacy CPA

Other Needs:

- Age Gap between peers
- Carers, to be listened to and heard.
- To use language that will be understood
- Co-operative
- Less formal clinical reviews partnerships
- Clear treatment philosophy and vision
- Validation and understanding of rationale
- Carers, not to be judged
- Associate practitioners
- Hygiene
- Carers, team work
- Speedy assessment, easy access to service. Only one assessment
- Flexible accessible service
- Relaxation techniques
- Complimentary therapies
- Thoughtfulness for each other
- Age – when does a young person become an adult
- Not to encourage over dependence. Too much medicalising
- Use of more/different medication
- Take some responsibility for own health

THE 20 PRIORITY NEEDS OF OUR CHILDREN, YOUNG PEOPLE, FAMILIES AND CARERS

Priority Needs		Who currently meets the need	Who could/should meet the need	Suggested changes
1.	Respectful, 2 way communication between all parties using therapeutic listening skills	MDT	Us and users, families, carers, outside agencies	Shared core philosophy and support/supervision/training to embed in culture. This already happens but needs to be consistent. More staff to go on therapeutic communication course at Essex Uni - could be run at <<<<<<<<. Use of plain language. Outlook/visible diary.
2.	Education, support groups etc	Nursing staff	Parental mental health group T4. In house to communicate with community staff to share groups	Formalise a generic support group. Yearly event past and present (RAPP). Link worker from social care. School reintegration role for a member of the Outreach team. Improve team approach from our team – work together rather than as individuals.
3.	Consistent working practices between MDT and outside agencies	MDT & Crisis Outreach	Multi-agency Link workers, social care, school re-integration/social inclusion worker	More flexible timetable (Outlook/visible diary). Change care co-ordinator workload expectations if young people in <<<<<<<< to allow for time to attend reviews, CPA's, Individual work, telephone liaison and face to face E.G, consider new ways of working – reconfiguration link clinician from each CMAHS base. Primary/secondary tasks MDT – releasing time to care.
4.	Different Therapies/therapist	Nobody at present	Local organizations linking in with <<<<<<<< i.e. drama workshops. Link person to facilitate i.e. Outreach.	Trained therapist – funding (outside agency)
5.	Clearly defined aims and goals of admission	Admitting nurse, assessing team, MDT Gate keeping	Key worker identified before admission to carry out assessment at home base pre and post admission. Integrated model care.	Clear language. Integrated model of care. At assessment we manage to formulate and do the 4 P's but don't always get to the fifth P – plan – we need to do this. Pre and post assessment liaison.
6.	Clear, concise language understandable to all. Use of	School, Bus Group,	Nursing team, Trust, more payphones.	Access to laptops on unit. Us accepting modern communication. Appropriate risk, instead of risk. More

	media i.e. mobiles & Internet	Payphone (Ltd), unescorted leave		payphones
7.	Breaking down barriers and stigma surrounding mental health	Whole of <<<<<<<<. World Mental health day. PALS facilitators i.e. at Col Utd Match	Schools, terms used, families, police, national/Gov	Informed society. More public consultation, opening event to de-mystify. Service user art work in exhibition in Colchester then in Unit. Greater use of world mental health day etc (currently covered in youth awareness programme). Normalisation annual event in the community to provide access to professionals – to answer questions re adolescent mental health.
8.	More community outings/activities	Education, nursing (although restricted)	Voluntary drivers, community support workers, group work nurse, co-ordinator, housekeeper	Less restricted (Section 3 SHCA). Evening therapeutic programme and weekend. Charge nurse activity group co-ordinator to include.
9.	Access to Physical health activities i.e. gym/instructor and awareness of healthy eating/housekeeper/dietician s	Nursing and education. LA Fitness. Mersea Outdoors	Dietician, housekeeper, outside agencies, personal trainers. Weekends, 7 days	Parking on playground, letters of complaint, check deeds. Gym. Training room in new unit – staff trained to use? Use of outdoor play area/court. Housekeeper – healthy fresh food.
10.	Raise awareness of parental mental illnesses	Family therapy. RAPP. Clinical staff	Outside agencies, cross referrals and joint work systems.	Communication and joint working between services (adult and child). Adult mental health input for parents – this should be seen as part of our remit as it impacts on the youngsters. Group for parents with mental health difficulties.
11.	Consistent Care Teams	Made up of MDT, key worker, co-worker FT, teachers RC, care co-ordinator	Crisis Outreach, Charge Nurse to ensure consistency supported by Rota's and processes.	In order to maintain consistency (where possible) we need to acknowledge that people are not interchangeable. The core team need to meet staff need to be enabled to attend formulation and other core team meetings.
12.	Develop comprehensive	MDT and Acute	Care Bundles developed by steering	A steering group to develop/introduce care bundles and

	treatment package	services manager. Parents/service users	group evidenced by Outcomes. SD&A group, complimentary alternative therapies	identify training needs and staff development. Use QNIC.
13.	Access and training in non-verbal communication practices to ensure inclusion for all i.e. blind, deaf, language barriers	Outside agencies	Staff member training in sign language and lip reading (not staff but outside training.	Basic training for some staff in signing etc. Increased awareness of the needs of others. Increased access to signers etc. TTY – machine – communicate – access to deaf society – consultation. Central <<<<<<<< email account NHS – safe and confidential parents – disability/communication.
14.	More training for nurses about physical problems disorders so not always relying on duty Dr etc.	SHO, Duty Dr, GP's on call A&E?	Judith Skargon, Physical health nurse, associate practitioners, eating disorder nurse/dietician, nurse prescriber	Judith to be asked to provide training in basics physical health needs. Youngsters should not be sent home to go to the GP. Improve consistency. Associate practitioners. Nurse prescriber. Training/link nurse for eating disorders and dietician.
15.	Links with local universities so that we are research aware	Internal training	Expert lecturers on development. Essex Uni/ARU	We need to link with Essex Uni and Cambridge to bring greater understanding of the theories of child development and adolescence. To raise the status of the Unit and the self work of the staff. Lead person to be identified to liaise with research outcomes. Staff to be enabled to attend courses, study days etc. Feedback to the team
16.	Carers – working in partnership. Being involved more and given more and better support	Nursing staff, teachers, advocates, admin, consultant, psychologist, Social worker, Outreach (pre & post discharge for N.E.	Could all meets needs better. Parents/carers within groups post discharge. Outreach team offering support post discharge. T4 Carers group/ coffee evening	More time to enable the improvement in communication. Training courses. Better resources. Setting up groups – for post discharge – Outreach to do. More funding for more groups. Parents/carers support group. Sunday evening when returning youngsters. Coffee available. Opportunity to chat with other parents.

17.	Clear understanding of child and human development	Consultant, psychologist, therapist, S.W. Nurses i.e. Biological & psychological	Nursing staff (with training). All LV Staff. Promote learning environment.	More training for all staff. Funding for resources training. <<<<<<<< specific – core skills. Use QNIC training manual. Mentoring- learning from established members of staff. Run the Essex course at <<<<<<<<
18.	Young people to be given better understanding of different mental health problems so not to behave insensitively amongst other young people.	Nursing and teachers, community meetings	All staff/ young people during peer groups.	Used more in classroom/group setting on a more regular basis rather than just 'Mental Health Day'. Make board/leaflets about different mental health problems and what people may see/experience at <<<<<<<< and how to manage their feelings etc, around this. Shared framework for community meetings. Somewhere to note down issues on the unit.
19.	Income benefit housing, further education needs, coping with isolation	Unit Admin, Connexions, Advocate, social worker, teachers	Nursing, social worker, designated person within Trust, CAB	Have a designated person to liaise with rather than rely on own knowledge. Use advocates/social workers more. Have more leaflets available. Support them in own community (isolation).
20.	Parents/Carers to be better informed as to what is happening to their youngster. Understanding the process. Better communication with carers by preferred method of email, text, phone or in person	Tier 3 staff upon admission/before admission. All staff. Assessing team	All staff across Tier 3 and 4	Information to be given when informed of decision to admit. Preferred contact face to face or over phone – only texts etc for hard of hearing, ask for preference. Skype / Bluetooth.

WHAT NEEDS TO CHANGE?
Based on the information gathered throughout the CTCYP process and the completion of diary sheets, individual capability profile, working differently handout and team capability profile

New Ways of Working

- Use Band 6 'floater' to free up nursing skills – releasing time to care
- Training SHCA's to fill vacancies
- Flexible/rotating posts. Opportunity to move around organisation (but maintain stability) all team
- Charge Nurses? T3/T4
- Review MDT Meeting – Daily MDT meeting/ consistency/ communication/ decision making
- MDT daily presence
- Program – groups with MDT – portfolio of interests. Also backed up with training and supervision e.g. CBT/ACE
- Develop roles/ systemic family therapist/MDT/Specialist nursing
- Shift work for all
- Re: think qualifications – think outside of the box in developing roles i.e. therapists/occupational therapists.
- Nurses to join/contribute to PSHE/Youth awareness with education department.
- Close working with medics re: medication/psychological therapy
- More emphasis on families/systems.
- Family therapy suite
- More intensive and variety of approaches/locations
- Career progression/pathway (see also new roles/specialism's)
    - Specialists – band 6/7 – enable career progression.
    - Currently no career progression for nurses within team - career ladder
    - Good Career Ladder – Secondments
    - Education – no career pathway
- Gaps for Occupation Therapy
- Formalise generic support groups.
    - In house
    - Parental support groups
    - Shared by all staff
    - Setting up parents groups – for post discharge
    - More funding for more groups.
    - Parents/carers support group. Sunday evening when returning youngsters.
    - Coffee available. Opportunity to chat with other parents.
- Yearly event past and present (RAPP).
- Link worker from social care.
- School reintegration role for a member of the Outreach team.
- Improve team approach from our team –
    - Work together rather than as individuals.
    - More flexible timetable (Outlook/visible diary).
    - Change care co-ordinator workload expectations
    - Reconfiguration link clinician from each CMAHS base.
- Consistent care teams
    - The core team need to meet

    - Staff need to be enabled to attend formulation and other core team meetings.
- Explore releasing time to care.
- Use trained therapists form outside agencies
- Introduce Evening/weekend therapeutic programme
    - Charge nurse activity group co-ordinator

New Roles

- STR posts (Support Time Recovery)
- Housekeeper (band 3)
    - How to use vacancy
    - expand role to support social skills, personal hygiene and nutrition
    - benefits young people/meets national requirements/infection control/ECM
    - support provision of healthy diet/fresh food
- Advanced practitioner role
    - RC = Responsible clinician
    - Non medical prescribers
- Band 4 – Assistant practitioner
- Specialist roles
    - Eating disorder specialist/Nurses
    - Learning Disabilities specialist
    - Nurse specialism to fill gaps and develop new roles (cost effective)
    - Re: thinking roles e.g. best practice. Roles using evidence and ensuring implementation. Nurses – specialism e.g. Psychosis
- Associate practitioners to focus on physical health
- AMHPS - Help eliminate some of the problems seeking medical opinion for section 17 leave etc.
- Social Care/worker
    - Proposal for Social worker in Crisis Outreach and T4 skill mix
    - Social care deficit – link worker (CP) to T4
- Parent advocate Role – Education community link or work
- Art therapist
- Dietician – with wider service
- Group work co-ordinator
- Community liaison/activity worker to work against stigma and to maintain links with the community (normalisation)

Learning and Development

- Training/Supervision
- Age appropriateness
- Nurse
- Good education model
- Forensic Training
- Actively offer opportunities to ALL staff who wish to develop and progress
- More joint working – learn from each other
- Improve awareness of evidence based practice
    - Develop a link with Essex Uni and Cambridge to bring greater understanding of the theories of child development and adolescence.

    - . Lead person to be identified to liaise with research outcomes.
    - Staff to be enabled to attend courses, study days etc. Feedback to the team
- More training for all staff.
- Funding for resources training. <<<<<<<< specific – core skills.
- Use QNIC training manual.
- Mentoring- learning from established members of staff.
- Run the Essex course at <<<<<<<<
- Training and time to enable the improvement in communication.

Others

- Improve Communication with/for young people
    - CAMHS Glossy brochures
    - Crisis cards
    - Use of plain language
    - Access to laptops of unit
    - Us modern methods of communication
    - More payphones
    - Post risk taking
    - Basic training for some staff in signing etc.
    - Increased access to signers etc.
    - TTY – machine – communicate – access to deaf society –
    - Central <<<<<<<< email account NHS
    - Safe and confidential parents – disability/communication
    - Shared framework for community meetings
    - Somewhere to note down issues on the unit
- Raise MH awareness of young people
    - in classroom/group setting
    - Make a board/leaflets about different mental health problems
- Improve Communication with each other
    - Shared core philosophy
    - More staff to go on therapeutic communication course at Essex Uni - - could be run at <<<<<<<<.
    - Visible outlook diaries/Transparent diaries – shifty
- Parents/Carers to be better informed as to what is happening to their youngster
    - Help them understand the process
    - Better communication with carers by preferred method of email, text, and phone or in person, ask for preference. Skype / Bluetooth.
    - Communication with parents
    - Information to be given when informed of decision to admit
- Information to be given when informed of decision to admit. Preferred contact face to face or over phone – only texts etc for hard of hearing, ask for preference. Skype / Bluetooth
- Communication and joint working between services (adult and child).
- Adult mental health input for parents
    - This should be seen as part of our remit as it impacts on the youngsters.
    - Group for parents with mental health difficulties.
- Integrated model of care
    - Clearly defined aims and goals on admission
    - get to the fifth P – plan at assessment
    - Pre and post assessment liaison.

- Develop comprehensive treatment package
    - A steering group to develop/introduce care bundles
    - Identify training needs and staff development.
    - Use QNIC.
- Break down barriers/stigma
    - More public consultation, opening event to de-mystify
    - Service user art work in exhibition in Colchester then in Unit.
    - Greater use of world mental health day etc
    - Annual event in the community to provide access to professionals – to answer questions re adolescent mental health.
- Crisis line i.e. Neril
- Access to physical health activities
    - Gym or training room on new unit
    - Staff trained to use
    - Use outdoor play area
- Address physical health needs
    - Judith to be asked to provide training
    - Young people should not be sent home to go to the GP
    - Improve consistency.
    - Training/link nurse for eating disorders
    - Access dietician.
- Address Parking on playground
    - Letters of complaint, check deeds.
- More promotion and awareness i.e. RAPP group – kids group – discussion/debates/stigma.
- Program to adjust for non-mandatory education aged YIPS? Role e.g. job coach, in-reach connections group focused and intensity
- Program – motivational therapy/work. Motivational speakers
- Structure – revamp CPA/CMM/Review processes and requirements. Efficient, avoid duplication
- Crisis Outreach Bus (timetable)
- Provide help and advice in relation to housing, further ed and isolation
    - Have a designated person to liaise with rather than rely on own knowledge.
    - Use advocates/social workers more.
    - Have more leaflets available.
    - Support them in own community (isolation).

TEAM CAPABILITIES ✓ = Have/need X = Don't have/ 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																			
Change/staff initials		DY	CS	TR	DM	MQ	LB	GJ	BO	LM	AM	TW	CS	MG	DJ	PP	JW	KB	SB	NH
1.	Respectful, 2 way communication between all parties using therapeutic listening skills	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N	✓	✓	✓	✓	✓	✓	✓	✓
2.	Education, support groups etc	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N	✓	✓	✓	✓	✓	✓	✓	✓
3.	Consistent working practices between MDT and outside agencies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N	N	✓	✓		N	✓	✓	✓
4.	Different Therapies/therapist	✓	✓	✓	✓	✓	✓	✓	✓	✓	D	✓D	✓D	✓	✓	✓	✓	✓	✓	✓
5.	Clearly defined aims and goals of admission	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	D	✓	✓	✓
6.	Clear, concise language understandable to all. Use of media i.e. mobiles & Internet	✓	✓	D	D	D	C	✓	✓	D	✓	✓	✓	✓	✓	D	C	✓	✓	✓
7.	Breaking down barriers and stigma surrounding mental health	✓	✓	D		D	✓	✓	✓	D	D	D	D	✓	✓	C	D	✓	✓	✓
8.	More community outings/activities	✓	✓	C	D	D	C	✓	D	C	✓	✓	✓	H	✓	D	H	H	D	H
9.	Access to Physical health activities	✓	D	D	D	D	D	✓	✓	D	✓	✓	✓	N	✓	D	D	H	H	H
10.	Raise awareness of parental mental illnesses	✓	D	D	✓	D	D	D	✓	D	D	D	D	✓	✓	C	D	✓	✓	✓
11.	Consistent Care Teams	✓	✓	✓	✓	✓		✓	✓	✓	D	✓	✓	✓	✓	✓	✓	✓	✓	✓
12.	Develop comprehensive treatment package	✓	✓	✓	✓	✓	D	D	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
13.	Access and training in non-verbal communication i.e. blind, deaf, language barriers	C	D	D	D	D	C	D	D	D	D	D	D	N	✓	C	D	D	C	C
14.	More training for nurses about physical problems disorders	D	D	D		D	C	X	D	D		D	D	X	D	C	D	N	D	✓
15.	Links with local universities so that we are research aware	D	D	D	✓	✓	D	D	D	D	D	D	D	N	D	D	D	✓	D	H
16.	Carers – working in partnership.	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	D	✓	✓	✓	✓	✓
17.	Clear understanding of child and human development	✓	✓	D	✓	D	✓	✓	✓	✓	D	D	D	✓	✓	D	✓	✓	✓	✓
18.	Young people to be given better understanding of different mental health problems	✓	D	D		D	D	D	✓	D	D	D	✓	✓	✓	D	X	✓	✓	✓
19.	Income benefit housing, further education needs, coping with isolation	✓	D	D		D	C	D	D	D	D	D	D	C	D	C	N	N	X	X
20.	Parents/Carers to be better informed as to what is happening to their youngster i.e. email, text, phone or in person	D	✓	✓	✓	✓	D	D	✓	✓	✓	✓	✓	H	✓	✓	H	✓	✓	✓

Red = development required **Amber = some development/skill sharing required** **Green = most staff have the required skills**

Blue = further exploration required

CTCYP Action Plan – Green Changes (quick wins, easy changes, can be achieved by team)

Green changes	Actions Required	By whom	By when	Resources required	Cross ref	
To provide parents with appropriate forms of support	For <<<<<<<< to provide an in-house parent support group. Refer parents to other groups as appropriate (external)	Group co-ordinator	On-going	Appropriate room/facilitator x 2 plus cover for facilitators		
To create a career pathway for SHCA's	Identify band 4 posts in the new unit. Enable staff access to appropriate training (e.g. therapeutic communication course at Essex University)	Unit Manager	On-going	Training budget		
To create a staff resource library at <<<<<<<< (to include appropriate professional journals)	Identify a room. Identify a responsible person. Budget for resources	Psychologist. Assistant & SHCA ?	End of July	Budget for resources		
To improve written communication between <<<<<<<<, young people and their carers	Create CAMHS specific leaflets and brochures. Consult with young people and carers about the content of these leaflets. Liaise with Trust publications department	Admin staff				
Offer or consider more family therapy time	To empower nurses to do family work. Provide them with training and protected time. Staff to work with family therapist Matthew Ganda. Link with Crisis Outreach family therapist	L and M	6th May 2010		SUI 4.1	

Organise training for staff re understanding the complex and challenge of young people with co-morbid conduct disorder and mental ill health	Via in-service training and in clinical supervision	MDT strategy team members and clinical supervision	End of year for training. Immediate for supervision	Dedicated training time	SUI plan 21.7, 21.8	Target dates yet to be arranged
Joint working - nursing and education To improve team working and to demonstrate to young people that we are one team	Indentify appropriate links in both teams. Daily MDT meetings PSHE sessions in class. Physical activity sessions – in and out of education time Re-integration to school – outreach worker Through meal preparation	A and shift-co-ordinator C and L L/G P/shift co-ordinator	In place one month Two months In place In place	None if ward is settled and nurse can be spared	SUI 21	On-going On going
To increase understanding of other roles within CAMHS	Teams to agree secondment opportunities • Crisis / Outreach • YOT • Shadowing • EIP • Pastoral roles in school Police CAIU	L L L G Social worker	In place	Backfill Good	SUI 2	

Better communication within the MDT. Sharing of responsibility of decision making. Greater involvement of senior team.	Daily clinical meeting of MDT. Clinician of the Day system	Shift co-ordinator COD	In place and on-going	Dedicated time (already allocated)	SUI 13@ 10.4,13,14. 1,14.2, 20.1, 22	Good – review regularly
More visible COD of the day	Attending nursing handovers Attending daily MDT meeting COD Rota in place	L	Already in place		SUI 4, 21, 13	Appears to be working well. Monday MDT not taking place due to weekly reviews
Community meeting. How is it facilitated	This is to be looked at/explored within the <<<<<<<< group programme	K & S	25th June 2010		SUI 21, 21.3, 21.5	Community meeting takes place each morning at 9am. Staff concerned about consistent approach to this group.
Building on positives rather than the negatives	To be addressed in IPR and supervision process. Activities, away days. Team building. Formal and informal team building	IPR cascade (supervision) Monthly <<<<<<<< pub outing Angela	End of August 2010 27th May 2010		SUI 21.5	IPR cascade is now in place
Team Ownership. Team understanding in process	Complete CTCYP process. All to implement the SUI action plan	L	October 2010		SUI 21.5	CTCYP training in process. SUI action plan being implemented.
Improved documentation Case files, care plans Up to date risk assessment	All staff fluent in and regular areas of Carebase Daily kept up to date by all clinical staff Keep care plan notes updated daily	All staff	Imminent Ongoing Ongoing	Carebase training Time Review and handover	SUI 5, 6, 8, 10, 14, 15, 16, 17.i, 19.i, 20, 22	

To ensure that all clinicians working diaries and commitments are accessible to the whole MDT	For clinicians to enter weekly diary on outlook	All clinicians	End of May	Initial training (I.T.)	SUI plan 21.2	Target set.

CTCYP Action Plan – Amber Changes (need more time and may need reallocation of resources)

Amber changes	Actions required	By whom	By when	Resources required	Cross Ref	Progress
Community / In-house education	Rolling road show of teaching/clinical/philosophical workshops	Separate Disciplines	Summer 2010	Modest teaching aids e.g. PowerPoint etc	SUI plan 13i, 21 v,vi,vii	
7 day programme	To create educational, cultural, activities, social sporting functions 7 days per week.	Management and disciplines (new disciplines such as OT needed)	January / April 2011	New staff, additional shifts	SUI plan 13ii, 9 19, 21	
To empower and enable young people to access community resources prior to discharge	Young people to visit job centre, housing office etc	Key worker	Sept	Time to investigate resources. Time to take youngsters out.		
To ensure effective and non-discriminatory communication methods with parents/carers	On admission identify parental responsibility – should both parents be contacted. Document young person consent to contact parent/carers Safe use of email, texting (further exploration) telephone letter, signers, interpreters i.e. effective/preferred methods of communication	Admitting nurse (who hands over to key worker)	Lizzy, June 31	Kelly to develop new form to doc this info by admitting nurse Resource free		
For the nursing team to improve expertise in (common) physical health problems.	Nurses to receive necessary training. Junior Dr to be available to consult/prescribe if necessary	J Charge Nurse to plan	Will depend on availability of resources	Time for training More medical cover		None

To develop an ongoing group programme. To prepare a specific group programme for school holidays in advance	Therapeutic, sound educational needs of fluent group met. Programme agreed, facilitators identified course materials prepared	S K		Time to organize and pre-pare. Depends on group – art equipment paperwork, DVD's. Sufficient staff		In development currently
Clinical audit CPA Progress	Files/care plans up to date CPA/CMM reviews	Consultant acute service manager. CAMHS director MDT	Summer 2010		SUI plan 3i, iii, 4i, 5iii, 6i, 10i, ii,iii,iv, 11i, ii, iii,iv, 14i, ii, iii, iv, v. 15, 16, 17i, ii, iii, 19, 20i, 22	
Safeguarding recording and reporting	Daily screening and H of Safe guarding reporting	SW and Charge Nurse	Immediate ly		SUI plan 10i, ii,iii, iv,	
Admission of client – Identify core team	Meet objective of core team within 5 working days. This will include initial formulation meeting on admission	Key worker (nurse) Co-worker. Allocated at time of admission	Present			On-going
Ambience of working environment	Visitors and staff to create an atmosphere where staff feel valued and feeling part of the organization	Modern Matron (housekeepin g)	October 31st 2010	Funding for pictures, flowers, furniture and paint.		Each part of the team to take responsibility for their offices. Group work can address this art work communal areas.

CTCYP Action Plan – Red Changes (longer term/complex changes, may require SMT approval)

Red changes	Actions required	By whom	By when	Resources required	Cross ref	Progress
To have a nominated person who will liaise with care co-ordinator in CAMHMS Tier 3 to report upon outcomes of assessments, weekly reviews and other key care/treatment/safeguarding issues.	To ensure the client and or clients families treatment needs are understood by all professionals involved and changes are communicated promptly and effectively.	Senior clinical (COD) if involved in assessment. Charge Nurse if attending weekly review	Immediate	None	SUI plan 17.1, 17.2, 17.3, 18	Mostly achieved
CAMHS dietician	Advise clinicians Tier ¾ in managing eating disorders. Linking with paediatric physical healthcare and other specialist eating disorder services Undertaking assessment and providing direct clinical care	I T	June 2010	1 person WTE		ongoing
Responsible clinician	Decision making regarding young people who are formally detained Risk assessment Leave planning Tribunals/appeals	Currently Dr H	SUI action (7) plan recommended this is reviewed. Unknown date for this to happen			ongoing
Explore potential of nurse prescribing role. (relates to SUI action plan 7.2)	To be able to prescribe medication to young people when medics are unavailable	L	Unknown	Funding for course		

Art therapist	Increase the range of therapies available to young people. Need to explore potential opportunities e.g. alternative funding sources, art therapy students, volunteer work.	L	Unknown	Research into local options/potential opportunities with Essex Uni for example		
Housekeeper	Consideration of: cook freeze/cook chill employ 2 OT's work with dietician	L	Nov 2011			
Strike better balance between clinical and management roles	Work plans for every member of staff. Meaningful IPR's Mindful rota system	IPR Cascade	30th august 2010	With current resources (resource neutral)	SUI 3, 21, 13	C/N and new nurses
Breakdown barriers and reduce stigma by developing public awareness	Public awareness Have a stand at local exhibition or gallery. Link with Trust communications dept Link/liaison with schools to discuss mental health Community mental health workshops Mental Health Day	L L and S M Q M	August 2010 July 2011 May 2010 May 2010 Oct 2010	Resource neutral art therapist and Deborah Creed.		
Liaison work with other agencies that may need to work with clients and/or families i.e. benefits, housing, connexions	To help to achieve independence. Skills and resources. For the core team to identify social care issues based on information gained at the CPA assessment. Create a needs plan from this	Social worker. Education Team (representative) Nursing team	From admission of each client	Protected time for core Team planning meeting	SUI plan 1,2,8,9,10,11,14,19,20	Very good thinking. Connexions worker, Nicki Gatsby. MIND Advocate already in place

	information that is related to the formulation arrived at after initial assessment.	(representative) Key worker				
To provide access to physical activities on the Unit	Staff to be adequately trained to supervise youngsters when using gym equipment. Explore and identify appropriate courses	Departmental managers	Ongoing	Training budget		

CTCYP Action Plan – 2 High priority Red Changes to take to SMT

Red changes	Actions required	By whom	By when	Resources required	Cross ref	Progress
1. To provide age appropriate care 2. To provide appropriate education16+ but particularly those not in employment or ed (training)	Follow CPA policy surrounding transitional care More individual programmes possibly incorporating Connexions, OT programme Review the group programme, Individual needs and care as opposed to age defined.	Intranet G J S and K	Immediately Summer 2010 Immediately	Computers Education Resource Small Meeting	SUI plan 4,6,8,9,10,13, 18,19,20	
3. Facilitate transitional to adult care if necessary	Establish working links with adult services. Identify link person	DM and Key worker	Summer 2010	AMS Co-ordinator		
4. to develop a learning environment that promotes evidence based practice a) to develop in-house induction and training programme b) Access to external training services	Analysing evidence/need for integrated model Identify directory of skills within existing workforce. Time table annual programme of in-house training. Team training and dev day Clinical skills identified in IPR Training proposal written and submitted to management	Clinical service group C S L L Strategy group	 31st May 10 28/2 & 30/9	QNIC evidence base to Tier 4 Resource free Protected agenda time – strategy group management/clinical supervision	SUI 10, 11 Safeguarding 3 22.4 Observation – AB 22.3 Risk assessment – LB 14,17,18 CPA	

The Team Profile and Workforce Plan is completed throughout the CTCYP 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 children, young people, families and carers
- The 20 priority needs of the children, young people, families 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 children, young people, families 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