

Mental Health Policy Implementation Guide

Community Development Workers for Black and Minority Ethnic Communities

FINAL HANDBOOK



READER INFORMATION

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Mental Health Policy Implementation Guide

**Community Development
Workers for Black and Minority
Ethnic Communities**

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Preface

Community Development Workers (CDWs) will work with and support communities including the Black and Minority Ethnic (BME) voluntary sector, help build capacity within them, and ensure the views of the minority communities are taken into account by the statutory sector during planning and delivery of services.

In launching the *Delivering Race Equality (DRE) in Mental Healthcare* Action Plan in January 2005, the Government has acknowledged the important role that the BME communities themselves will have in bringing about change. *DRE in Mental Healthcare* is the Government's 5 year Action Plan for tackling the inequalities in services and care for BME groups. The engagement of the communities is an important consideration in this context and the aim in introducing these new workers is therefore to help build recognised capacity and capability.

Ministers have been clear that implementing DRE is in the very top rank of priorities for Mental Health (MH) services. Implementation is necessary to ensure compliance with race relations legislation and core standards on equality and discrimination, and to take forward the Government's wider social inclusion and community development programme. Delivering the Action Plan is also ethically and clinically essential.

Community development is an integral part of our attempts to improve MH services so that they can meet the needs of minority ethnic groups effectively. Our assumption is that reform 'inside' the mental health system must take place in tandem with investment and developments 'outside' the service in order for this to be meaningful and successful. The national programme to improve services and care for people who use MH services from the BME communities is clear on the importance of this role for CDWs. This commitment is backed by our resolve to fund 80 community engagement projects as part of the preparation to recruit 500 CDWs nationally.

These new workers are expected to work at senior level and alongside the regional Race Equality Leads (RELs) within health and social care, focusing on improving commissioning, access, experience and outcomes of all ethnic minority communities as defined within the DRE Action Plan.

This guidance supports but does **not** replace the two earlier related publications in December 2004 and October 2005, and clarifies any ambiguities that may still exist about the role and function of the CDW. In particular, I would draw your attention to section 10.2 and Appendix D about *A “month” in the life of a CDW* that provides greater, more detailed clarity about the role. The investment in CDWs is a significant step towards achieving an inclusive approach in dealing with health inequalities both at the community and service level. The potential for these new workers in highlighting and tackling health inequalities within the BME communities is very promising. However, their effectiveness depends on local health and social care organisations taking a positive and proactive approach in their recruitment, development and retention. Without this support, the MH needs of people from the BME communities will fall short of what the DRE Action Plan aims to deliver.

Professor David Sallah

National Director

Care Services Improvement Partnership DRE Programme

Introduction

1. As part of the Government's intention to develop and expand the MH workforce and to help improve the care and treatment of people with a mental illness from BME communities, two pieces of guidance have already been published to help support the introduction of CDWs.
2. The purpose of the Interim Guidance¹ published in December 2004, was to provide a framework for local health and social care systems to introduce CDWs into the MH workforce and the purpose of the Supplementary Guidance² was to provide an appropriate framework for the Education and Training (E&T) of CDWs.
3. These two publications have given sufficient information to allow local health and care systems, working closely with their appropriate Strategic Health Authority(ies) (SHAs), to start employing CDWs by way of Early Implementer Sites (EIS) (see Appendix A) as part of the wider DRE initiative.
4. The EIS were set up to help get the CDW programme up and running but this function is now being taken forward by the DRE Focussed Implementation Sites (FIS).
5. However, experience has shown, that no matter how well guidance has been prepared, there will always be some points of detail that will need clarifying once a programme to introduce a new type of worker has commenced.

Purpose

6. The purpose of this Handbook is to provide an update on the new CDW Interim Milestone and to answer those issues that need clarification in the light of experience in introducing and developing the CDW workforce. It does **not** replace or supersede the earlier guidance, rather it amplifies those points of **detail which** have arisen in practice.

1 *Mental Health Policy Implementation Guide* Community Development Workers for Black and Minority Ethnic Communities – Interim Guidance: December 2004: Department of Health publication number 265796

2 *Mental Health Policy Implementation Guide* Community Development Workers for Black and Minority Ethnic Communities: Education and Training – Supplementary Guidance: October 2005: Department of Health publication number 271259

Who is this Handbook for?

7. The Handbook is for all those organisations involved in the introduction and development of CDWs and include:
- Primary Care Trusts (PCTs);
 - MH Trusts;
 - Foundation Trusts;
 - Children's Trusts/Children Centres;
 - Local Authorities (LAs) ;
 - Voluntary Sector organisations;
 - SHAs and their Workforce Development Directorates (WDDs);
 - Commissioners and providers of E&T; and
 - Service users and carers.

What are they expected to do?

8. The Handbook provides a resource in support of the two pieces of earlier guidance. It should help clear up any lingering doubts or questions to enable local health and social care systems to get started with or support and further develop new and existing CDW programmes.

New CDW Interim Milestone

9. Appendix B contains the letter issued by the Minister of State for Health Services in October 2006 clarifying the importance of the CDW programme within the DRE strategy. Her letter also provides a covering note to a letter from the Department of Health (DH) that not only confirms that the CDW programme has been fully resourced but also, it sets out details of the new CDW Interim Milestone. Essentially, whilst it confirms that PCTs are expected to recruit 500 CDWs, the new date for recruitment is revised *from* December 2006 *to* December 2007 but with a new, interim milestone of at least 50 per cent of CDWs to be in post within each SHA by March 2007. Annex B to the DH letter also sets out the CDW allocations in respect of the new SHA configurations that took place in July 2006.

Key learning points

Community Development Workers

Developing Community Connections

- 10.1** Community development work can be an unfamiliar concept to many, so a paper on “Developing Community Connections”, produced by the Community Development Foundation, is set out in Appendix C. This may assist both individual CDWs and their employers gain a better understanding of what is involved.

CDW Role

- 10.2.1** Although the Interim Guidance sets out the role of a CDW³, it is clear that some localities have not fully grasped (yet) that the CDW has a strategic role rather than being a support or link worker whose focus is concentrated on the individual service user. To help get a better understanding of their role, Appendix E sets out what has been called **A “month” in the life of a CDW**. This should be read in conjunction with Appendix C – Developing Community Connections.
- 10.2.2** Appendix C sets out the *values* of working with communities where it is crucial to start by working with people in communities and community organisations to plan for change and take collective action; to support communities to monitor, evaluate and review action for change; and to help develop community organisations. This form of process activity will help CDWs recognise and meet communities where they are at in their stage of development.
- 10.2.3** The aim of Appendix D, which is about *actions*, is to give a flavour of the sort of strategic activity a CDW might undertake to help them fulfil the role successfully. It does not set out to provide a comprehensive inventory of things or tasks a CDW should do. It is not intended to be some form of “tick list”.
- 10.2.4** The title of A “month” in the life of a CDW should not be taken literally. No one is suggesting this can all be done in a month and the job is then complete – it’s not that easy! A “month” could also read “Three/six months....” etc etc.
- 10.2.5** Despite what is now a very comprehensive set of guidance that clearly sets out the role, in many ways, on appointment, a CDW starts with a blank canvas. This is not a process driven role where in response to situation X a CDW will (automatically) do Y. As indicated in the Person Specification in the sample Job Profiles in Appendix C of the Interim Guidance⁴, a CDW needs to be someone who adopts a flexible approach and has the ability to work independently and on their own

3 Paragraphs 1 to 14 on pages 8 to 11 and Appendix A on page 21

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initiative. It is not expected that as soon as they identify an issue, they can simply look up a manual to find the answer – no such “template” exists – or always turn to their manager for advice. As the Person Specification goes on to say, they will be expected to have the “ability to deal with complex issues facing vulnerable groups in the community”.

10.2.6 This does not mean they are or should be on their own, isolated from other staff working in MH services – far from it. The Interim Guidance⁵ makes it quite clear what on-going support and supervision a CDW might expect. A CDW should also work in conjunction with and as a member of the Local Strategic Partnership (LSP)⁶ and any DRE Sub-Group that may exist locally. Paragraph 35 of the Interim Guidance is particularly important and some localities, such as the Care Services Improvement Partnership (CSIP) Development Centres (DC) for London, the North East and the West Midlands, are introducing or supporting a CDW network/e-mail forums to help share experiences, problem solving etc. See also Appendix L.

10.2.7 As the Interim Guidance⁷ makes clear, coupled with the information set out in Appendix D about the activities a CDW might expect to undertake, one of the really key things a CDW needs to identify are local (strategic) trends or themes then, working with others, take action to help resolve them. (The Interim Guidance provides a good example of the latter⁸). It is these trends or themes, rather than what happens to any one individual service user, that will provide the foundation for their work; provide the context for change; and help drive the agenda forward. Examples of this, including what *may be the reasons* why they are happening, might be as follows:

- An increase in the numbers of BME service users being admitted to hospital;
 - *[a lack of appropriate services in the community/discharges happening too early?]*
- An increase in the numbers of BME service users being sectioned under the Mental Health Act;
 - *[a lack of understanding what the alternative solutions might be? Are they in place?]*
- An increased use in medication being offered to BME service users;
 - *[a lack of alternative “talking” therapies being available or valued?]*

5 Page 16

6 Paragraph 8

7 Paragraph 19

8 Paragraphs 12 and 13

- An increase in the number of BME service users being made homeless;
 - *[is poor or unsuitable accommodation bearing down unfairly on the BME community?]*
- An increase in the number of BME service users attending Accident and Emergency departments;
 - *[a lack of understanding by the BME community itself of more appropriate alternatives?]*
- An increase in the number of BME service users having financial problems;
 - *[a lack of help being given by Benefits Agency staff to help BME service users to claim appropriate social security benefits]*
- Very few BME service users able to gain or sustain employment;
 - *[Job Centre staff and local employers unaware of the particular needs of the BME population or the support they may require]*
- An increase in the number of domestic violence cases in BME families;
 - *[Is this about greater incidence or improved reporting?]*
- An increase in the number of cases of Deliberate Self-Harm;
 - *[the effect of the recent closure of a “refuge” run by the voluntary sector set up to tackle this issue and more awareness and reporting by MH workers]*

10.2.8 It is recognised that the examples quoted above and the reasons *why* things are happening may both be rather simplistic and not wholly complete. However, this should not detract from the underlying **principle** or message that CDWs need to identify the trends; analyse the reasons behind what is happening; and with others, work out what needs to be done, by whom, when and what support or resources they require at a strategic, developmental level. It is not (necessarily) about *directly* helping “Mr or Mrs X in Waveney Drive” to effect a change in their individual, personal circumstances although the strategic changes will help them down the line.

10.2.9 Identification of trends will come from harnessing all the relevant data/statistics/contacts that may include:

- information from Public Health eg morbidity and mortality data;
- local libraries eg local surveys, reports, research, details of local support groups/networks;
- the local NHS Trusts;

- the appropriate SHA;
- the LA;
- Local voluntary sector organisations;
- local Department for Work and Pensions office(s);
- Local Implementation Teams (LITs) – eg DRE Sub-Groups;
- LSPs;
- GP surgeries – Local Medical Committees;
- appropriate publications such as Annual Reports or Consultation documents;
- census and demographic data to include numbers, their age, sex, and ethnic breakdown;
- deprivation data;
- information on languages spoken;
- Job Centres;
- the internet; and
- local education and training providers, local Learning and Skills Councils etc.

10.2.10 This information, coupled with a thorough knowledge of the service user pathways, should help CDWs get off to a flying start in undertaking a challenging and vital role where they will hold a unique position to see the whole health and social care picture for and on behalf of the BME communities they serve.

New workers?

10.3.1 By introducing CDWs, it is clear the Government's intention is to expand the MH workforce by recruiting new or additional members of staff. However, three different approaches have emerged:-

New workers

- Some PCTs have taken on new, additional staff to undertake the CDW role fully in line with both the Interim and E&T Supplementary guidance.

Conversion

- Some localities have felt a number of their existing workforce are already carrying out a broadly similar role and wish to convert their current role and/or title to that of a CDW for BME communities.

Re-deployment

- This is where a PCT or MH Trust takes an existing member of staff (from whatever job (s)he may be doing), turning them into a CDW as per the Interim and E&T Supplementary guidance, but then not filling the vacancy (for whatever their original post was) that is left behind.

10.3.2 In an attempt to help with the conversion process, the CSIP/National Institute for Mental Health in England (NIMHE) has produced some **revised** guidance which is at Appendix E. Regardless of the job title, PCTs should be able to show clearly how individuals are fulfilling the four key roles of a CDW, and that this role is not merely an addition to their previous role but is making an effective contribution to DRE.

10.3.3 It is for the SHA to “performance manage” these changes, taking advice from the REL in the appropriate CSIP DC as necessary.

Part time or Job share posts

10.4.1 Questions have been raised about whether the CDW job can be carried out on a part-time or job-share basis. What is important is that the job is not seen as some form of “add on” to a person’s other, non-CDW duties. Not only does this carry the perception the CDW role is not important but it fails to recognise the challenging nature of the job. More importantly however, such an arrangement may then make very little difference being felt in the BME community thus defeating the objective of introducing CDWs in the first place. It is, of course, good practice for PCTs to consult the RELs and agree locally on how best to organise and deliver the CDW function.

What do CDWs mean to BME service users?

10.5.1 CDWs mean:

- Helping BME communities to feel included
- Meeting with service users on their own territory at
 - Day centres
 - Drop in’s
 - Meals and socials/clubs
 - Anywhere service users might go
- Proper publicity of the rationale and role
 - Across all stakeholders

- Across Community MH and other Teams
- Via psychiatrists, nurses and other MH staff
- Recognising what service users expect
 - More responsive services eg
 - Working with care co-ordinators
 - Looking at pathways to care
 - Better capacity building
 - Helping to develop advocacy services
 - More respect
 - Less apprehension/fear of MH services
 - Justice and independence
 - CDWs to be trained/informed by service users
 - Better information
 - Contributing to the co-ordination of ethnic recording/monitoring
 - Contributing to a BME directory of services, contacts etc
 - Across health, education and social care particularly the voluntary sector

Involving service users in the development of CDWs

10.6.1 It is important to adopt a flexible approach in the introduction and development of CDWs that is not seen as an imposition from the Trust or employer. Effective engagement with service users, who may themselves be CDWs, is very important and Appendix F gives some pointers about how this might be undertaken.

CDWs for Child and Adolescent MH Services (CAMHS)

10.7.1 As indicated in the E&T Supplementary Guidance, CDWs can be employed to work across the full age range of MH services. Plymouth has recruited a CDW to work in their Early Years Community Well-being Team and the succeeding paragraphs set this out in a bit more detail. Copies of the Job Advertisement and Job Description/Person Specification may be found at Appendix G1 and G2 respectively.

10.7.2 In Plymouth, the specifics of the CDW role are to help develop community based early interventions for vulnerable BME families with young children (0-5). Given the well-documented problems around access to services for such groups, this has involved opening new pathways to care, principally through the CDW's developing

good relationships with the BME voluntary and community sector, but also through direct and informal interaction across the city's BME population. The broad aim is to ensure that vulnerable BME children presenting behavioural/emotional difficulties are supported earlier and more creatively within the family and community, hopefully in an appropriate and parentally empowering way that does not later mean the children end up in more acute CAMHS tiers unnecessarily. However, although all of the direct interventions by the teams' Primary Mental Health Workers and Specialist Early Years Educational Psychologist have at their heart a spirit of MH promotion, more complex needs can be escalated by the team to involve specialist CAMH services. This is a process that can be disempowering for parents but which can be supported by the CDW as an advocate, a role that also allows the team to address the holistic needs of a family by supporting issues potentially detrimental to good MH such as housing, employment, welfare, racial harassment and language/adult learning. Such 'soft' child-centred interventions, away from the 'clinical' language of mental illness, enable the CDW to actively promote an understanding of positive MH that can unpick some of the stigma surrounding the issue.

10.7.3 Plymouth has little genuine 'grass roots' community infrastructure in common with more established areas of diversity across the country. Given the rapidly diversifying demographic of the city however, there is a need to help develop generic capacity building projects across all communities that are inclusive and open. It is to be noted that with an abundance of intellectual drive and commitment to their communities, many of these BME groups are pragmatic enough to actively seek out developmental support and are fully engaged with those externally seeking to support them. Nonetheless, managing expectations and overstating the practical successes that working with a CDW can achieve remains an ongoing challenge. Some instances of capacity building work currently being undertaken are:

- An award of £36K (bid for by the CDW) from an under spend in the Local Education Area budget for 2005/06. This money was used to support children's access to culturally appropriate and linguistically supportive community based resources. Community groups working were invited to choose and host appropriate resources for their communities. A crèche facility at a language school was developed, learning resources for an Islamic education charity were purchased, a stay and play group promoting positive early years MH and parenting for Plymouth's Traveller families, all are examples of work initiated from this award.
- The CDW, having identified a significant number of chronically isolated single mothers with young children and little English, facilitated the development of a group called First Steps at Manor St Children's Centre (a Sure Start initiative).

Offering free ESOL classes and childcare, the aim of the group was simply to offer the potential for a naturally self-sustaining social network to emerge that would help reduce the women's isolation and the threat to their and their children's long-term mental health this could pose. Meeting once a week, access to a Health Visitor (an area of unmet need) is now regular while the CDW is able to signpost individuals into appropriate services and/or act as an advocate around other issues such as housing, welfare and employment. Led by one of the team's Primary Mental Health Workers, there are plans to develop a 'Stay and Play' session each week that promotes positive infant MH and boosts parental confidence capable of reducing stress.

10.7.4 Much of the CDW's role as a 'change agent' involves strategic influence and the training of health/education (Tier 1) professionals. Psychological evidence has revealed that children as young as 18 months are able and begin to register negative social messages around race and stereotypes. In Plymouth, this has informed a city-wide initiative (led by the CDW) to place equalities co-ordinators in every Early Years setting. This ensures practice is non-discriminatory and actively builds confidence, self-esteem and fluid multiple identities in all children, and that serves to facilitate their ability later in life to move across cultures confidently and without the 'fear' that can influence prejudiced attitudes or poor MH. This is understood to be of great importance in significantly 'white' dominated areas, where contact with cultural difference is almost non-existent in real-life. It is planned that the emerging Primary Mental Health Worker role (which has much in common with that of the CDW) will also facilitate the DRE agenda becoming embedded in Tier 2 Community CAMHS as a core competency.

10.7.5 Contact point – simon.newitt@plymouth.gov.uk

CDWs for Older People's MH Services (OPMH)

10.8.1 The importance of developing culturally appropriate services is identified as a cross-cutting issue in *Everybody's Business* (DH November 2005), the Department's new service development guide for older people's mental health services.

10.8.2 BME elders are at risk of social exclusion and are prone to depression and other mental health problems which may go untreated.

10.8.3 Barriers to access by BME elders are the same as those experienced by BME groups across the age spectrum. Barriers include:

- limited availability of intelligible information about the range of services available

- attitudes of service professionals
- cultural factors influencing the understanding and perception of mental illness within communities

10.8.4 There are two overarching principles that should underpin any strategy for delivering improvements to service design and delivery for BME elders. These are:

- delivering non-discriminatory, age inclusive MH and care services
- and holistic, person-centred older people's health and care services which address mental as well as physical health needs

10.8.5 Key recommendations for service improvement include:

- the development of appropriate and responsive services
- organisational and workforce development
- action to engage communities (including the development of CDWs to meet specific need)
- better information

10.8.6 The ethos of *Everybody's Business* is to ensure that OP with MH problems have their needs met and managed wherever they are in the system without encountering barriers to access or discrimination.

Delivering Race Equality (DRE)

11.1.1 The CDW function needs to be understood in the context of the DRE programme for tackling race inequalities in access to services, experience of services and outcomes from services. DRE is based on three main building blocks of reform, one of which is community engagement and development. Implementation of DRE is being led from within 17 FIS set up to develop and spread good practice. More information on FIS activity and DRE in general is available from <http://actiondre.org.uk> and www.bmentalhealth@dh.gsi.gov.uk

11.1.2 Islington PCT has developed a DRE Action Plan for 2005 – 2008 that incorporates the work of CDWs. Further information can be obtained from Bianca Kokkolas, Strategy and Commissioning Manager for Mental Health at Bianca.kokkolas@islingtonpct.nhs.uk

Examples of good practice

- 12.1.1** The CSIP/NIMHE **South East DC** has produced a **Toolkit** that aims to help managers with localised implementation of the CDW role. In the Toolkit, a “System Map”, produced by Jane Halloway and Barbara Evans from Hampshire, has been compiled that acts a guide when recruiting a CDW to post. It helps to determine the ‘why’, the ‘what’, the ‘how’ and the ‘by when’ questions as part of the implementation process. Relevant extracts of the Toolkit are shown in Appendix H and a full copy can be obtained from Poppy Jaman at poppy.jaman@sedc.nhs.uk
- 12.2.1** The CSIP/NIMHE **London DC** has produced a **progress report** “Could do better? Community Development Workers in London” that sets out a number of helpful points that includes recruitment and utilisation of CDWs against the DRE programme. Copies can be obtained from Denise Bobb at denise.bobb@londondevelopmentcentre.org
- 12.3.1** Appendix I sets out a synopsis of the **CDW developments** in **Sandwell PCT**.
- 12.4.1** Appendix J sets out the **CDW Audit Tool** developed by **Cumbria and Lancashire SHA** in conjunction with Northumberland, Tyne and Wear SHA to help both PCTs and SHAs in the delivery and monitoring of CDWs.
- 12.5.1** In **Birmingham and Solihull Mental Health Trust**, the role of an Asian CDW is to enable service users, their carers and the Asian community as a whole to gain a better understanding of mental health issues and to gain easier access to mental health services. Examples of positive practice include the following:
- Promoting positive mental health talks on Asian radio stations, which have enabled people to call in and discuss any concerns that they have. This raises awareness of mental health issues in the Asian community and it has been encouraging that people have felt confident to call in and ask for further information about relevant services anonymously.
 - Delivering talks to small Asian community groups and at different places of worship ie gurdwaras, mosques, and temples. Attending Asian events, running display stalls to provide information and distribute leaflets in various Asian languages at special religious occasions like Diwali, Vasakhi, and Eid Melas. People access this information easily in familiar settings such as this.
 - Forging links with the Asian Community by networking with community groups such as Asian Warden-Controlled Accommodations, Day Centres, and Asian Resource Centres etc has enabled further inroads to be made to break down the barriers and stigma regarding mental health in the Asian Community.

- In collaboration with voluntary and statutory sectors support workers, establishing an Asian Carers' support group to support Asian Carers. The aim of the group is to provide networking and information for Carers. The success of this group has been to enable carers to gain a better knowledge of mental illness and to find appropriate resources i.e. respite care.

Contact point – Surinder Gill – Surinder.Gill@bsmht.nhs.uk

12.6.1 A CDW for the Irish community has been set up in the **Heart of Birmingham**.

The aim is to work in partnership with all appropriate agencies to support the development and provision of an integrated service, that brings together opportunities for improved health, social care, housing, income, work, and leisure to meet the needs of people with mental health problems within the Irish Community.

Contact point – Michelle Bhalroo – michelle.bhalroo@midlandheart.org.uk

12.7.1 Walsall PCT has developed a **commissioning strategy** for CDWs that incorporates the proposal that the PCT act as the host provider and that the CDW's should be managed within Public Health. The objectives and core activities of the CDW's will be agreed and monitored by the MH BME Steering Group. Joint operational management will be provided by the MH Social Care Lead for Diversity and the Deputy Head for Health Promotion who will oversee the professional development of the CDWs and ensure robust links with Strategic and Commissioning elements of the MH service.

12.7.2 Through its seven year Health Action Zone (HAZ) programme, Walsall PCT has developed an approach to community development work that has successfully engaged with communities and delivered a number of innovative programmes and projects. These have empowered and involved communities in addressing health inequalities. The structure recommended will build on the existing success of Public Health Community Facilitators who work with Community groups and communities to deliver planned programmes in relation to health inequalities across the borough of Walsall.

12.7.3 Community Public Health Facilitators have on the whole focused on physical health. It is proposed that the CDW's integrate within the existing structure and have a specific mental health development remit. By integrating the work of CDWs with part of the role of Community Public Health Team and the Health Promotion Team, the Trust believes it has a unique opportunity to align the aspirations of the CDW role with broader agendas of well-being and regeneration ensuring strong links to LSPs and the development of Local Area Agreements.

- 12.7.4** The BME Community Development and Mental Well Being team will be a virtual team comprising of Specialist MH BME CDWs that will work alongside the Community Public Health team and Health Promotion department and will be fully integrated into the Public Involvement and Regeneration structure. Contact point: Karen Williams, MH Service Improvement Manager
Karen.williams@walsall.nhs.uk
- 12.8.1 Southwark** (Southwark Council and South London and Maudsley NHS Trust) has begun to establish a **Forum** for the development of the CDW role. See Appendix K for their draft Terms of Reference. Contact point is wayne.amiel@slam.nhs.uk
- 12.9.1** The **West Midlands** have set up a **CDW Network** and their (draft) Terms of Reference are at Appendix L. Contact points is ranjit.senghera@csip.org.uk
- 12.10.1** Additionally, the **West Midlands** has appointed a **Senior CDW** and a personal explanation of the role as well as an outline Job Description are set out in Appendix M1 and M2 respectively.

Additional Education and Training Issues

Race Equality and Cultural Capability (RECC)

- 13.1.1** Learning materials comprising 12 sessions covering 3 modules are being developed on RECC which form a further stage in the implementation of the Ten Essential Shared Capability (ESC)⁹ project. The RECC materials will be a series of team based educational activities that promote personal reflection, team discussion, service development and organisational action for staff working in MH services.
- 13.1.2** The RECC programme focuses on the practitioners in MH understanding the personal experience of BME mental health service users and supports practitioners to challenge inequality with a focus on race and culture.
- 13.1.3** The learning materials set out the key values and principles for promoting equality and diversity in MH with a focus on race and culture. The initial part of the materials will emphasise the crucial importance of reflective practice before going on to define some fundamental concepts for racial equality and cultural diversity. Finally, the main elements of practice to promote equality and diversity with BME individuals and communities will be covered. Overall, the materials are divided into three Modules entitled:
- Self-awareness

9 The Ten Essential Shared Capabilities – A Framework for the Whole of the Mental Health Workforce: August 2004: Department of Health publication number 40339

- Race equality and culture
- BME mental health practice.

13.1.4 The contact point for these learning materials is Ian McGonagle at imcgonagle@lincoln.ac.uk

Examples of commissioning and provision of E&T

13.2.1 In the West Midlands, **the Heart of Birmingham PCT** has contracted with the Tavistock Management Centre in London to develop and deliver an E&T programme for CDWs and their host organisations. This will cover:

- The role of CDW;
- Knowledge of the key sets of needs and issues facing the BME communication in Birmingham;
- Application of a socio-political and psychosocial framework to understanding the BME organisations and people;
- Understanding institutional cultures in relation to difference and race;
- Becoming a change agent;
- Service development;
- Capacity building;
- Access improvement; and
- Evaluation and Feedback.

Contact point is safina.mistry@hobtpct.nhs.uk

13.2.2 CSIP South West is commissioning a CDW E&T package from the Institute of HealthCare Studies at Bournemouth University. The university intends to offer a part-time programme equivalent to 60 credits of learning. Providing that students undertake units from the Post-graduate Continuing Professional Development (CPD) framework, the University is able to offer academic accreditation for this learning for those who are eligible to study at the appropriate level. This level of credit is equivalent to half of a full-time year of study and positions students well to progress to completion of additional study towards Honours or Masters degrees as appropriate should they wish. Contact point is Clive Matthews, Head of Education and Management – clive.matthews@bournemouth.ac.uk

13.2.3.1 Touchstone – Leeds is a major non-statutory provider of community based MH services in Leeds. It has developed an induction and training package for its team of 8 CDWs, in partnership with Leeds Metropolitan University (LMU).

- 13.2.3.2** Initial discussions took place between Touchstone-Leeds, Leeds North West PCT, and the West Yorkshire Workforce Development Directorate (WYWDD). Five local Higher Education establishments were identified as potential partners – all these establishments already received monies from WYWDD to provide a range of courses.
- 13.2.3.3** Touchstone asked each establishment to consider the DH Supplementary Guidance for CDW E&T and to propose a training package. In order to keep development costs to a minimum, potential partners were asked to differentiate costs for elements imported from existing courses funded by WYWDD; elements which could be modified from existing courses; and the elements unique to CDW requirements.
- 13.2.3.4** LMU's proposal was a 4-module Certificate in Mental Health and Community Development, pitched at Level 1 and delivered over 7 months. The first two modules are delivered intensively over 4 weeks, with some elements shared with students of International Development, and Youth & Community Studies. The final two modules are spread over 6 months, and are completed on a day release basis alongside Primary Care MH Workers and Support Time and Recovery (STR) Workers.
- 13.2.3.5** Leeds MH Trust is providing additional training in the Ten ESC.

Module 1:

- Models & Principles of Community Development (CD) and
 - Models and Models and Values in MH
-

Module 2: Community Development & Mental Health

- Developing practice skills and linking these to CD theory
 - Application of CD to MH promotion Tackling inequalities
 - Working with diversity
 - Developing advocacy
-

Module 3: History, Legislation and Policy

- History will be overview of developments in MH and Social Care over last 50 yrs;
 - Legislation will cover aspects of Community Care, MH Act, Race Relations, Equality & Disability Legislation;
 - Policy to include how these have been applied and impact on BME communities etc
-

Module 4: Personal Learning & Development

- Ongoing process of integrating of theory into practice
 - Production of practice portfolio with focus on National Occupational Standards (NOS) in CD & NOS for MH
-

- 13.2.4** CSIP North West has commissioned **Salford University** to deliver a pilot Post Graduate Certificate training for CDWs which is intended to commence in February 2007. Contact point is a.rimmer@salford.ac.uk

Agenda for Change (A4C)

- 14.1** One key issue around the introduction of CDWs, has been the question of what level of pay is appropriate. The Interim Guidance made it quite clear, as does the DH letter in Appendix B, the level of funding included in PCT baseline allocations provides for a salary of £25,000 (£25K) and the normal 'on costs'. This salary level applies to CDWs who work across the whole age spectrum as well as those who might just work in CAMHS or OPMH services for example. The Guidance also made it clear that it is open to local employers to pay a higher salary if they believe it is justified on the grounds of experience, qualification, degree of responsibility etc but any sum over and above the indicative sum of £25K, will have to come from their own resources.
- 14.2** The figure of £25K was settled some time ago primarily for two reasons. First, it was to take account of what was considered should be the appropriate financial reward for the role and function of a CDW. Second, it was part of the bids made by DH under the normal wider Government Spending Review process that takes place some time in advance of introducing a policy, in this case, the implementation of CDWs into the MH workforce.
- 14.3** What has happened in the mean time, is the introduction of A4C as part of the intention to both simplify and effectively reward staff working in the NHS, not just MH services, for their level of responsibility. Although a decision has yet to be taken nationally on the appropriate Band for CDWs, it is already clear from work done in the CSIP South East DC that CDWs fall into Band 6. Whilst Band 6 may be regarded as the norm, inexperienced practitioners may be appointed at Band 5 but be expected to progress to Band 6. See Appendix N1 along with the appropriate sample Job Description at Appendix N2.

Career Development

- 15.1** As part of the CSIP South East DC Toolkit (Appendix H), they have set out some thoughts about Career Development and this is at Appendix O.
- 15.2** In paragraph 39 on page 17 of the Interim Guidance, mention was made about the development of the Career Framework for the NHS. Details about progress and how to obtain the Skills for Health Career Framework Resource Pack, can be obtained via careerframework@skillsforhealth.org.uk

Evaluation of the CDW Programme

Department of Health (DH) Policy Research Programme

- 16.1** The introduction of CDWs into the MH workforce has been included as part of the DH Policy Research Programme that aims to find out the impact of New Roles, such as CDWs, on staff and services and associated outcomes for service users, their carers and their families (where appropriate). The Research Programme is expected to report in 2008.

Summary

- 17.1** The introduction of CDWs represents a very important milestone in the Governments' desire to improve the delivery of MH services to people from BME communities. However, CDWs have a huge agenda before them that may seem very daunting and they may wish to consider setting up their own CDW networks to exchange ideas, share intelligence etc. They need to work in partnership with a wide variety of stakeholders to include the RELs; NHS, social care and other organisations; front line staff; and management within the framework of the LSP arrangements.
- 17.2** Both employers as well as the CDWs themselves need to recognise that it cannot all be done at once. Working within the context of the Local Delivery Plans (LDPs) and Race Equality Plans (REPs), they need to establish priorities and potential outcomes together with their LITs and PCTs and to "schedule" remaining issues that need to be tackled, thus developing a common agenda and timescales.
- 17.3** Despite what are now three pieces of Guidance on CDWs, it is inevitable that this will not be the end or the complete story – other issues are bound to come up. These should be tackled on a pragmatic basis that clearly supports the Government's policy aims to help sustain the BME community, in a collaborative manner across health and social care, taking account of local needs.
- 17.4** The RELs in each CSIP/NIMHE Region – see Appendix P – who together, form a very useful and well-qualified network, should always be the first point of call, in trying to resolve any future problems.

Appendix A

CDW Early Implementer Sites (EIS)

Host Organisation	Address	Project Lead	E-Mail	Phone Numbers	CSIP/NIMHE Region & Race Equality Lead
North Dorset PCT	Forston Clinic, Herrison Road, Dorchester, Dorset	Jayne Ray	Jayne.ray@northdorset-pct.nhs.uk	01305 361366 Fax – 01305 361330	South West: Mark Patterson
Dorset Healthcare NHS Trust	C/o St Ann's Hospital, 69 Haven Road, Canford Cliffs, Poole, BH13 7LN	Jane Elson	Jane.elson@dorsethc-tr.swest.nhs.uk	01202 705548 Fax – 01202 705616	Mark Patterson
Somerset Coast PCT	2nd Floor, Mallard Court, Express Park, Bristol Road, Bridgwater, TA6 4RN	Yvonne Vigar	Yvonne.vigar@somcoastpct.nhs.uk	01278 432026 Fax – 01278 432099 01278 432055	Mark Patterson
		Loretta Ingram (CDW Manager)	Loretta.ingram@somcoastpct.nhs.uk		
Oxford PCT	Richards Building, Old Road, Headington, Oxford	Yvonne Taylor/ Amer Akbar	Amer.akbar@oxfordcity-pct.nhs.uk Yvonne.taylor@oxfordcity-pct.nhs.uk	01865 226629 01865 227176	South East: Poppy Jaman
Eastern Leicester PCT	2nd Floor, Enkalon House 92 Regent Road, Leicester, LE1 7PE	MeenaAckbarally/ Shabana Janjua	Meena.ackbarally@elpct.nhs.uk Shabana.janjua@elpct.nhs.uk	0116 2951429/ 4193 0116 2954106	East Midlands: Asha Day
South Warwickshire PCT	St Mary's Lodge, 12 St Mary's Road, Leamington Spa, Warwickshire, CV31 1JN	Bob Peel	Bob.peel@swarkpct.nhs	01926 339261 Fax – 01926 435202	West Midlands: Ranjit Senghera
Dudley Beacon & Castle	St. John's House, Union Street, Dudley, West Mids, DY2 8PP	Jacky O'Sullivan	Jacky.Osullivan@dudley.nhs.uk	01902 575929 Fax – 01902 575923	Ranjit Senghera
Walsall PCT	Dorothy Pattison Hospital, Alumwell Close, Walsall PCT	Jim Warburton	Warburtonj@walsall.gov.uk	01922 643650	Ranjit Senghera
South Birmingham PCT	Selly Oak Health Centre, 15 Katie Road, Selly Oak, Birmingham, B29 6JG	Cherry Dale	Cherry.dale@sbpct.nhs.uk	0121 4728046 Fax – 0121 4727354	Ranjit Senghera
Birmingham & Solihull Mental Health NHS Trust	Longbridge Health & Community Centre, 10 Park Way, Rubery, Birmingham, B45 9PL	Lakhvir Rellon	Lakhvir.rellon@bsmht.nhs.uk	0121 678 2000	Ranjit Senghera

Host Organisation	Address	Project Lead	E-Mail	Phone Numbers	CSIP/NIMHE Region & Race Equality Lead
Sandwell PCTs	Sandwell PCT Kingston House West Bromwich	Lesley Brougham	Lesley.brougham@os-pct.nhs.uk	0121 525 5000	Ranjit Senghera
Haringey Mental Health Trust/Vol Organisation	3rd Floor, Cumberland Road, Wood Green, N22 7SG	Gerry Atkinson/ Siobhan Harper Tony Thake	Gerry.atkinson@haringey.gov.uk	0208 4893633/3508	London: Denise Bobb
Tower Hamlets PCT	5th Floor, Aneurin Bevan House, 81 Commercial Road, London, E1 1RD	Angela Yphantides	Angela.yphantides@thpct.nhs.uk	0207 4566773	Denise Bobb
Leeds – Touchstone	2-4 Middleton Cres Leeds LS11 6JU	Alison Lowe Jon Beech (CDW Co-ordinator)	alowe@touchstone-leeds.co.uk jonb@touchstone-leeds.co.uk	0113 271 8277 0113 219 2722	North East, Yorks & Humber: Selina Ullah
Building Bridges (Royal Liverpool Children's NHS Trust)		Iyabo Fatimilehin	Iyabo.fatimilehin@rlc.nhs.uk		North West: Manjeet Singh
Preston PCT (Preston CAMH service)		Edwina Dewhurst (CAMHs Clinical Manager)	Edwina.dewhurst@prestonpct.nhs.uk		Manjeet Singh

Appendix B



NEW CDW INTERIM MILESTONE

Richmond House
79 Whitehall
London
SW1A 2NS

From: The Minister of State for Health Services

Gateway ref: 7049

4 October 2006

Dear SHA Chief Executive

BLACK AND MINORITY ETHNIC MENTAL HEALTH

With this letter you will find a note from Duncan Selbie and Louis Appleby that redefines and clarifies our expectations for the recruitment of community development workers for BME mental health. I want to make the Government's position on this, and on the wider BME mental health programme, perfectly clear.

The quality of mental health care for BME communities in England is not acceptable. To be blunt, services are discriminating in a way that is arguably both unethical and unlawful. Communities feel alienated from NHS services and many are deeply mistrustful of them. This fuels a vicious circle of fear that deters people from seeking help early in their illness.

If anyone still doubts that, I suggest they examine the considerable body of evidence that has accumulated over the years. Last year's Count Me In census confirmed that people from certain ethnic groups are much more likely than others to follow coercive pathways to care, and to be subject to measures like seclusion and restraint once in hospital. Later this year the Mental Health Act Commission and the Healthcare Commission will publish a report of interviews with hundreds of service users about their experiences, and the results of this year's census; you should expect both documents to reaffirm the scale and severity of the problem.

I know that the factors underlying this situation are complex and still not fully understood. That is not an excuse for inaction. Last January we published *Delivering Race Equality in Mental Health Care*, a comprehensive plan based on years of consultation and advice from the leading experts in the field. DRE sets out 78 specific actions designed to improve services in 12 quantifiable ways. A lot of promising activity arising from the plan has already begun, but everyone involved in providing, managing or planning mental health services needs to understand and act on their duty to make DRE work.

DRE offers you a blueprint for reform, and one that we have underpinned with significant support and resources. Those resources include the £16 million a year now in PCT baseline allocations to fund 500 community development workers. So I am particularly disappointed with the rate of progress towards that objective. I am well aware that there have been financial constraints this year but we simply cannot allow that to lead to the abandonment of a top-tier priority for mental health.

I am not sure we have done enough to communicate how high a priority the BME programme is. That will change. Duncan's and Louis's note describes how we are firming up management of the CDW objective. The Healthcare Commission, the Mental Health Act Commission and the Commission for

Racial Equality are all taking a close interest in DRE implementation, and we will continue to encourage that interest and co-operate with them in identifying areas of weak performance.

No-one expects an overnight transformation. What BME communities have an absolute right to demand is recognition of the issues by all those responsible for mental health services in this country, coupled with a genuine and sustained commitment to change.

Services have achieved a huge amount since the publication of the mental health NSF in 1999, and I have every confidence in their ability to rise to this new challenge. The Department and the Care Services Improvement Partnership will keep offering support and guidance; I will continue to take a close personal interest in progress.

Yours sincerely,

ROSIE WINTERTON MP CBE

Minister of State for Health Services



*Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 5334
Switchboard: 020 7210 3000*

To: SHA Chief Executives
Gateway: 7049

cc: David Nicholson
Hugh Taylor
Sir Liam Donaldson
Richard Gleave
Surinder Sharma

4 October 2006

Dear everyone

MENTAL HEALTH: COMMUNITY DEVELOPMENT WORKERS FOR BLACK AND MINORITY ETHNIC COMMUNITIES

Summary

This letter follows up a discussion with your Directors of Performance at their meeting on 13 September. It clarifies some issues that have arisen around:

- the role of Community Development Workers;
- the funding that is in place to support their recruitment; and
- the management of progress towards the objective of 500 CDWs in post nationally.

It confirms that PCTs are expected to recruit 500 CDWs, and that SHAs are expected to manage PCTs' performance towards that objective. The target date for recruitment to be complete is revised to December 2007, with a new interim milestone of at least 50% of CDWs in post within each SHA by March 2007.

Background

CDWs support communities, help build capacity within them, and ensure their views are represented in statutory sector planning. They are a large and vital component of *Delivering Race Equality in Mental Health Care* (January 2005), our action plan for tackling the unacceptable inequalities in services for black and minority ethnic groups. Ministers have been clear that implementing DRE is in the very top rank of priorities for mental health services. Implementation is essential to ensure compliance with race relations legislation and core standards on equality and discrimination.

DRE summarises the role of CDWs (in paragraphs 3.112 – 3.117). More substantial guidance was published in December 2004, supplemented in October 2005 by guidance on education and training for CDWs. Web links to these three documents are contained in Annex A. Later this year DH will publish a handbook that draws on the lessons learnt since CDWs were introduced, but it will not replace or supersede the existing guides.

Funding and distribution of posts

The CDW programme has been fully resourced: £5 million was added to PCT baselines for 2004/05, rising to £16.3 million in 2005/06 and each year afterwards. This would fund the recruitment of 500 whole time equivalent workers at an average salary of £25,000 (equivalent to Agenda for Change Band 6) plus normal on costs.

The distribution of the posts was calculated per SHA, not PCT, leaving SHAs a role in allocating posts between PCTs. The distribution was published in the 2004 guidance, but Annex B aggregates those figures for the SHA configurations that took effect in July.

Definitions

A CDW can be defined as someone effectively performing a strategic role that:

- directly and actively supports implementation of DRE, in particular progress towards the twelve characteristics of a reformed service that DRE describes; and
- is fully consistent with the guidance referred to in paragraph 4.

CDWs are intended to be an addition to the mental health workforce and will normally be new recruits, although they may also be existing staff who have the training and skills needed to do the job. Job titles by themselves are largely irrelevant to the question of whether a worker is a CDW - what matters is their role and whether it meets the definition above.

Although PCTs receive the funding, they do not have to employ CDWs directly – for example, CDWs can be based in local authorities, mental health trusts or the independent sector.

Timescales

In January this year Durham mapping data showed 160 CDWs in post (Annex B breaks down that figure by SHA). The original objective was to have all 500 recruited by December this year. However, the limited progress made to date means this is no longer realistic.

We intend to respond to this by:

- setting a revised and firm target date of **December 2007** to have **500 WTE** CDWs in post;
- setting a new interim milestone of at least **50%** of the total **in each SHA area** (i.e. 250 WTE CDWs nationally) in post by **March 2007**; and
- making clear the importance attached to CDW recruitment and the expectation that SHAs should performance manage PCTs' progress accordingly.

There can be no further flexibility over the numbers of CDWs to be recruited or target dates. The Recovery and Support Unit at DH will include progress with recruitment in its discussions with SHA performance leads, beginning shortly with a review of progress to date and local plans for meeting the target.

Those initial discussions will be informed by updated figures obtained by local CSIP/NIMHE race equality leads (RELs). RELs will maintain a count of CDWs on their patch and share it with SHA performance leads, so that there is reliable data available between the annual Durham counts.

Queries

RELs can advise on issues like the CDW role and best practice in delivering it. Alternatively, queries about the content of this note can be directed to Jim Fowles, the policy lead for the BME mental health programme in DH: jim.fowles@dh.gsi.gov.uk (telephone 020 7972 4522).

Best wishes
Yours sincerely

Duncan Selbie
Commissioning Director

Professor Louis Appleby
National Director for Mental Health

Annex A

GUIDANCE ON CDW ROLE - WEB LINKS

Delivering Race Equality in Mental Health Care: an Action Plan for Reform Inside and Outside Services

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100773&chk=grJd1N

Mental Health Policy Implementation Guide - Community Development Workers for Black and Minority Ethnic Communities: Interim Guidance

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100931&chk=ia8y/t

Mental Health Policy Implementation Guide - Community Development Workers for Black and Minority Ethnic Communities: Education and Training Supplementary Guidance

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4120648&chk=0f60v%2B

Annex B

DISTRIBUTION OF FUNDED CDW POSTS BY SHA

SHA	CDW ALLOCATION (WTE)	IN POST¹
North East	31	7.8
Yorkshire & the Humber	54	12.35
North West	80	28.68
East Midlands	38	14.8
West Midlands	54	19.9
East of England	43	10.8
London	93	37.2
South East Coast	34	0.4
South Central	32	12.27
South West	40	16.3

1 Durham Mapping data, January 2006.

Appendix C

DEVELOPING COMMUNITY CONNECTIONS

1. Community development work may be an unfamiliar approach for many people. It can be difficult to describe and to predict because it should be about working with communities, responding to their needs and aspirations rather than simply meeting targets set by agencies or central government. In delivering the four key roles set out in the Interim Guidance, CDWs find themselves playing a hidden, but vital function, of helping communities and public services to make connections across organisational, identity and sectoral boundaries.
2. The principles and processes of community development work are rooted in firm values relating to participation, empowerment and learning. As an occupation, community development is about promoting social justice and social inclusion. In the context of the DRE programme for MH, the CDW is concerned with helping people from BME communities to combat institutional and inter-personal racism, and tackle the stigma and isolation faced by people with MH difficulties.
3. Strengthening informal networks helps communities to become more integrated, and provides individuals with the links they need to find support from friends and neighbours, and to access services. It also creates the foundation for communities to organise themselves collectively into self-help groups or voluntary organisations either to provide support services directly or to put pressure on the statutory services to become more appropriate to their issues and diverse cultures.
4. CDWs provide guidance and practical support in helping organisations to develop formal constitutions and funding arrangements, and ensure that they address exclusion and discrimination. They will also work with individuals to build their capacity and confidence to get involved and take on new responsibilities. For people with MH difficulties, this may require particularly sensitive and intensive support but it involves more than meeting someone's personal care or advice needs.
5. CDWs also have a role to play within institutions and in supporting partnerships. For community engagement strategies to be effective, evidence suggests that public bodies need to be prepared to change their 'normal' way of involving the public in consultation exercises. They need to move to a much more participative and empowering approach based on flexible liaison, active listening and a willingness to learn from the experiences that communities bring to the debate, including critical feedback and scepticism from some quarters. Community engagement and community care are not the same as community development, but both will be considerably enhanced by a solid basis of independent community-led activity that addresses issues identified by the communities themselves.
6. For the CDW to be effective in their roles as change agent, service developer, access facilitator and capacity builder, they need to develop and maintain good relations with a range of people and organisations. They also need to support the networking of others, encouraging people to reach out and extend their contacts and communication channels. As a professional working with people with MH issues, it is important that relationships are empathic but maintain clear role boundaries.
7. Connections across and between organisations can be both formal and informal, often facilitated through inter-disciplinary teams and multi-agency forums. The CDW can be instrumental in helping people to work through cross-professional tensions by focusing on the community's concerns and adopting a holistic or 'whole system' approach to meeting community needs and aspirations. By strengthening community connections, the CDW ensures that these perspectives influence decision-making from the bottom-upwards and that community members are aware of how they may obtain services and advice on MH problems.
8. CDWs use proactive outreach methods to overcome some of the barriers and biases encountered by BME communities in their dealings with the health services. They are often to be found working at the edges of organisations, building bridges and weaving webs that link people who might not otherwise discover what they have in common or how they can work together. This can require diplomacy and imagination, but also takes a great deal of time to build the levels of trust and respect that underpin successful collaborative working.

9. Not surprisingly, an approach that involves working across community and organisational boundaries can generate or reveal tensions arising from cultural differences and hostility, for example between different ethnic groups or due to bureaucratic targets and resistance to change. CDWs therefore need to be able to deal constructively with conflict and to be able to demonstrate the positive contribution that their work makes to the quality of life for mental health service users and BME communities.

10. Managers and commissioners of community development work need to understand the challenges that this approach poses for the hierarchical, output driven, clinically-based models that prevail in the health service. The effective deployment of CDWs raises complex issues around accountability and power, especially in relation to community representation and the management of diversity in service delivery. Such difficulties are not a sign of failure. They are inevitable and need to be worked through by workers, communities, managers and commissioners together.

11. It is a key function of CDWs to raise expectations and to encourage debate. A commitment to social justice implies that questions will be asked about resource allocation, equality of treatment and the distribution of power within organisations and within society as a whole. As an occupation community development work is concerned with tackling discrimination and promoting empowerment by working directly with the most marginalised groups. By helping people to develop connections within their own communities and with relevant agencies, community development work builds social capital, supports community engagement and ultimately ensures better service delivery.

12. None of this is easy, especially with workers covering large areas and based in organisations that may be unfamiliar with community development processes. It is therefore imperative that both workers and managers receive appropriate training and support so that they can rise to meet the challenge set by the DRE programme.

13. The Community Development Foundation offers training and consultancy support to help government and its agencies to work better with communities. See www.cdf.org.uk or contact Alison Gilchrist at Alison.Gilchrist@cdf.org.uk for further information and advice.

Appendix D

A “MONTH” IN THE LIFE OF A CDW

Introduction

1. The aim of this Appendix is to give a flavour of the sort of service activity a CDW might undertake to help them fulfil their strategic role successfully. It will almost certainly mean making personal contact with both those who are responsible for, manage and/or are closely involved with the activity or areas shown, to include service users, carers and families, against the backdrop of the information set out in paragraph 10.2.9 of the main text, coupled with appropriate local knowledge and intelligence.

2. The Appendix does not set out to provide a comprehensive inventory of things or tasks a CDW might undertake. Nor is it intended to be some form of “tick list” or to be used as a performance management tool. The areas or activity are not set out in any particular order of importance, magnitude or timescale. That is clearly for local determination.

Accident and Emergency Departments/Hospital wards/MH teams working in the community

- Are they aware of the DRE initiative and the role of the BME CDW?
- What education and training do they receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- What form of ethnic monitoring/recording takes place? What categories are used? What happens to that information? Is any analysis of that information undertaken?
- Are they aware of the effect mental illness has on the BME community? (ie more likely to be sectioned/have medication etc)
- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution? eg is it because they have failed to take their medication or have a dual “diagnosis of mental illness and drug/alcohol problems? Are more BME women attending/being admitted and if so, who are they and do they know why? eg are there more deliberate self harm cases?
- Is there a “general” or “common pathway/referral pattern in and out of their service and does this need to change? If so, how?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help?
- How many of their staff understand and/or speak a language other than English and what are those languages?
- Do A&E have much contact with local voluntary sector groups who may be able to help and support BME people who have a mental illness?

CAMHS

- Are they aware of the DRE initiative and the role of the BME CDW?
- Is there an explicit strategy for engaging with voluntary and community organisations working with children and young people, their families and carers?
- Do they have a list of all the relevant (statutory, non-statutory and educational) service and support organisations locally who may be able to offer help? What arrangements are in place to facilitate the regular input of these groups to CAMHS local needs assessment and service development?
- What E&T initiatives exist for staff to meet the Public Service Agreement (PSA) target of a comprehensive CAMHS in respect of RECC?
- What are the links and how are these established and maintained between Tier 1 and Tiers 2, 3 and 4 in CAMHS that ensure that the needs of BME children, young people, their families and carers are being met throughout the CAMH service?
- What outreach processes are in place to ensure that CAMH services are better placed to reach children and young people from BME communities?

- How many of their staff understand and/or speak a language other than English, what are those languages, and what knowledge does the CAMH service hold about the local language needs and access to appropriately trained interpreters?

Criminal Justice Services (Police, probation, courts etc)

- Are they aware of the DRE initiative and the role of the BME CDW?
- What is their understanding of mental illness?
- What is their attitude to mental illness?
- What education and training do they receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- Are they aware of the effect mental illness has on the BME community? (ie more likely to be sectioned/have medication etc)
- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution?
- How do they deal with people from the BME community who have a mental illness? What is the pathway into and out of their services? Does this need to change and if so, how?
- Who is best placed to make such changes and what support might they need?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? How often do they meet with them?
- How many of their staff understand and/or speak a language other than English and what are those languages?

Department for Work and Pensions

- Are they aware of the DRE initiative and the role of the BME CDW?
- What is their understanding of mental illness?
- What is their attitude to mental illness?
- What education and training do they receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- What additional help do they provide claimants/those seeking work from the BME community who have a mental illness over and above those with a physical illness? ie what adjustments do they make?
- Do they/are they willing to arrange for a “benefits seminar” for (leaders of) the BME community to help them both understand the benefits system and what they can claim?
- How many of their staff understand and/or speak a language other than English and what are those languages?
- What help do they provide for people from BME communities to enter into and remain in employment?
- What help do they provide for people from BME communities to set up, start and sustain their own business? Do they enlist help from the local Chamber of Commerce?
- Have they identified any learning or skills gaps in respect of people from BME communities that only apply to one particular section of that community or across the whole community?

Drug and Alcohol services

- Are they aware of the DRE initiative and the role of the BME CDW?
- What are their hopes and expectations of the CDW? [Explain role if necessary]
- What education and training do they receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- What form of ethnic monitoring/recording takes place? What categories are used? What happens to that information? Is any analysis of that information undertaken?
- Is there a breakdown of the BME people they see by age and sex? Are there any trends here?
- Are they aware of the effect mental illness has on the BME community? (ie more likely to be sectioned/have medication etc)
- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution?

- How do they deal with people from the BME community who have a mental illness? What is the pathway into and out of their services? Does this need to change and if so, how?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? How often do they meet with them?
- How many of their staff understand and/or speak a language other than English and what are those languages?
- How do they believe a community approach can help or be made to work to assist BME people who suffer from a mental illness and drug/alcohol problems?

Education services for children

- Are they aware of the DRE initiative and the role of the BME CDW?
- What is their understanding of mental illness?
- What education and training do the staff receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution?
- How do they deal with children from BME communities who have a mental illness? Who do they refer to?

Education services for adults of working age

- Are they aware of the DRE initiative and the role of the BME CDW?
- What is their understanding of mental illness?
- What education and training do the staff receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- Are they aware of the effect mental illness has on the BME community? (ie more likely to be sectioned/have medication etc)
- Are there any courses/modules they specifically offer people with a mental illness including BME communities that may help them cope with their mental illness? If so, how are these commissioned, how are they accessed and by whom?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help?
- How many of their staff understand and/or speak a language other than English and what are those languages?

Faith/religious communities

- What communities exist locally?
- Where are they?
- Which groups or parts of society/their faith-religion do they cover?
- Are they aware of the DRE initiative and the role of the BME CDW?
- What are their hopes and expectations of the CDW? [Explain role if necessary]
- Do they recognise mental illness?
- What is their understanding of mental illness?
- What education and training do they receive in respect of mental illness?
- What is their attitude to mental illness?
- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution?
- What support do they provide to members of their community (and their families/carers) who suffer from a mental illness?
- How do/should members of their community ask for support from them?
- What support do **they** need to help provide members of their community (and their families/carers) who suffer from a mental illness? Eg would talks to Asian community groups at different places of worship help such as gurdwaras, mosques and temples?

General Practice/Local Medical Committee

- Are they aware of the DRE initiative and the role of the BME CDW?
- What are their hopes and expectations of the CDW? [Explain role if necessary]
- What education and training do they receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- What form of ethnic monitoring/recording takes place? What categories are used? What happens to that information? Is any analysis of that information undertaken?
- Are they aware of the effect mental illness has on the BME community? (ie more likely to be sectioned/have medication etc)
- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution?
- How do they deal with people from the BME community who have a mental illness? What is the pathway into and out of their services? Does this need to change and if so, how? ie who tends to see people with a mental illness?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? Do they meet with them?
- How many of their staff understand and/or speak a language other than English and what are those languages?
- How does the Primary Care (Graduate) Mental Health Worker help in respect of people from BME communities with a mental illness?
- What additional support does General Practice need to help provide better services to people from BME communities with a mental illness?

Housing

- Are they aware of the DRE initiative and the role of the BME CDW?
- What is their understanding of mental illness?
- What education and training do the staff receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- Are they aware of the effect mental illness has on the BME community? (ie more likely to be sectioned/have medication etc)
- Does the local poor housing/accommodation bear down unfairly on the BME community? If so, what can be done to help overcome this problem?
- Do they recognise that poor housing may affect a person's mental well being?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? Do they meet with them?
- How many of their staff understand and/or speak a language other than English and what are those languages?

(Generic) Independent language/interpreter services

- What languages other than English are understood and spoken?
- What is their understanding of mental illness?
- Have they worked with people from BME communities who have a mental illness?
- Are they aware of the DRE initiative and the role of the BME CDW? [Explain role if necessary]
- What education and training do they receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?
- Are they aware of the effect mental illness has on the BME community? (ie more likely to be sectioned/have medication etc)
- What support do **they** need to help provide a service to members of the BME community (and their families/carers) who suffer from a mental illness?

Leisure services

- Are they aware of the DRE initiative and the role of the BME CDW?
- What is their understanding of mental illness?
- What education and training do the staff receive in respect of mental illness?
- What education and training do the staff receive in respect of Race Equality and Cultural Capability?

- What services can they offer people from BME communities who suffer from a mental illness? How can these be accessed? For example, if staff in the local MH Trust know that an hour's swimming at the local pool is a major help for service users to help them in coping with life's stresses, then how can the pool staff help the Trust to incorporate this in the service user's support plan, even while they are in hospital? How can the staff at the local pool, who will need to have their levels of understanding of mental distress raised and to be trained in the support of someone with temporary/cyclical mental distress, liaise with the Trust staff who will be required to support someone's swimming session. [Such a community response, 'opening up' ordinary, local facilities for service users will help to remove the stigma attached to people experiencing mental distress and help reinforce social inclusion].
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? Do they meet with them?
- How many of their staff understand and/or speak a language other than English and what are those languages?

Services to meet the needs of older adults

- Are they aware of the DRE initiative and the role of the BME CDW?
- Is there an explicit strategy for engaging with and supporting BME elders who have mental health needs?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? Do they meet with them?
- How many of their staff understand and/or speak a language other than English and what are those languages?
- What education and training do the staff receive in respect of Race Equality and Cultural Capability with regard to BME elders?
- What are the issues for staff from BME communities working with older people and how are they supported?
- What are the links between specialist secondary care services, primary care and the independent sectors and are the needs of BME elders adequately addressed throughout these sectors?

Local radio stations

- Do they exist? If so, where are they?
- Are they aware of the DRE initiative and the role of the BME CDW?
- What are their hopes and expectations of the CDW? [Explain role if necessary]
- Will they provide air time for a CDW to talk about their role, listen to concerns, help raise awareness?

BME Service User Groups

- Do they exist? If so, where are they?
- Which parts of the BME community do they cover?
- What happens to those who are not included?
- Are they aware of the DRE initiative and the role of the BME CDW?
- What are their hopes and expectations of the CDW? [Explain role if necessary]
- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? How often do they meet with them?
- What support do **they** need to help provide members of their community (and their families/carers) who suffer from a mental illness?

BME Voluntary sector

- Are they aware of the DRE initiative and the role of the BME CDW?
- What are their hopes and expectations of the CDW? [Explain role if necessary]
- What education and training do they receive in respect of mental illness?
- What education and training do they receive in respect of Race Equality and Cultural Capability?

- From their contacts, do they recognise any common threads or themes for those people they come across from the BME community? If so, what are they and what do they believe the options/solutions might be to tackle these? Who would be best placed to offer a solution?
- What support do they provide to members of their community (and their families/carers) who suffer from a mental illness?
- How do/should members of their community ask for support from them?
- Do they have a list of all the relevant (statutory and non-statutory) service and support organisations locally who may be able to offer help? How often do they meet with them?
- How many of their staff understand and/or speak a language other than English and what are those languages?
- What support do **they** need to help provide members of their community (and their families/carers) who suffer from a mental illness?
- Does the BME Voluntary sector know it has a place in Tier 1 of CAMHS and how this may be actioned?

Web media

- Do local web media exist? If so, in what form? How might a CDW gain access and contribute?
- Which (interest) groups or issues do they cover?
- Do they cover BME and mental illness?
- Would they be willing to cover and contribute to the DRE initiative and the role of the CDW?
- How will feedback be monitored and by whom?

Summary

3. As indicated in paragraph 10.2.7 in the main text of the Handbook, one of the key tasks is for the CDW:-

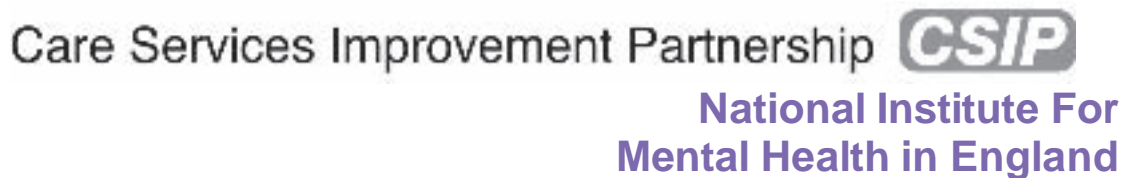
- to analyse what has been learnt by making personal contact;
- what might need to change both in respect of each area of activity and collectively across the locality and communities in the form of a joined up, community approach;
- how this might be brought about;
- what support may be required (eg better education and training); and
- how a “win win” situation can be achieved for both/all parties concerned.

4. This is all as part of being a *Community Development Worker*, applying the Four Key Roles of Change Agent; Service Developer; Access Facilitator; and Capacity Builder helping to achieve a *community* response in its’ widest sense to assist and support all those people from BME communities who suffer from a mental illness.

5. Finally, what is important of course, is being clear about what a CDW can deliver as opposed to what they can *influence* and being clear about what indicators or milestones can be agreed and put in place locally to measure outcomes. Both the BME community and the organisations that support them will want to know how successful the implementation of the CDW role has been across their patch. ie what difference it has made.

Appendix E

REVISED CONVERSION GUIDANCE



COMMUNITY DEVELOPMENT WORKERS (CDWs) for BLACK AND MINORITY ETHNIC (BME) COMMUNITIES: REDPLOYMENT OF EXISTING WORKERS

BACKGROUND

1. As set out in the CDW Interim Guidance (December 2004) and the Education and Training Supplementary Guidance (October 2005), there was a national target to introduce 500 CDWs by December 2006 designed to directly help support the key Ministerial priority of the Delivering Race Equality agenda. This target has now been modified whereby PCTs are now expected to recruit 500 CDWs by December 2007 but with a new, interim milestone of at least 50 per cent of CDWs to be in post within each SHA by March 2007.

2. As explained in paragraph 35 of the October 2005 guidance in particular, the CDW initiative is supported by £16.3m of new money in 2005/2006 recurring and this has been allocated to Primary Care Trusts (PCT) in the normal way. In line with the “Shifting the Balance of Power”, although the monies are not separately identified or ring fenced, the appropriate allocations have been made to the PCT baselines.

INTENTION

3. The clear intention therefore is that the CDW posts should be filled by new, additional recruits in mental health as part of the Government’s aim of expanding the mental health workforce. However, it is recognised that on the odd occasion, PCTs and other potential employers may wish to consider converting an existing worker.

POINTS FOR CLARIFICATION WITH THE EMPLOYER

4. Faced with this situation, SHAs, RELs etc may find the following helpful:-

a) Underpinning the whole initiative, there are two fundamental and closely linked points to remember. First, what lies behind the introduction of CDWs is not simply having another new (generic) support or development worker who may happen to or on occasion work with the BME community. It is about having a dedicated person working at a senior level who is solely focussed on improving the commissioning, provision, and access of MH services to and on behalf of the BME community by working directly with identified communities and all the relevant stakeholders as set out in the guidance. And second, it is about what is known as “fidelity to the model”. It is NOT therefore about having an existing support/development worker who may take on some of the CDW tasks and functions NOR is it about an existing support/development worker trying to do the CDW role in addition to their present duties.

b) So, if a PCT says they are converting an existing worker, it may be worth asking the following questions:-

- what is the basis or how can they justify why they think worker X or role X is now (suddenly) a CDW and where and in what form does the evidence exist? What has changed in the way the existing worker approaches the issues being faced by the BME community? ie what can the SHA/REL "see or feel" about what is different? **More importantly**, what difference will the BME community see from what is currently provided by that worker? Has formal or informal consultation been carried out with the worker and the community the worker works with, to determine what is different?
- how can the PCT or other employer demonstrate the converted role not only fits in with and meets ALL of the criteria as set out in the CDW guidance? Also, how does the role directly support the DRE Actions, and actions as devised by the steering group or working group put together to develop the programme of work for the CDW?
- can the PCT take the SHA/REL through the four key roles set out on page 21 of the Interim Guidance and show what the converted worker is either doing now or will be doing in the future?
- it is often the case that an existing (community) support worker has, as their primary function, the role of helping individual service users with their problems (eg housing, income, social support etc), or providing general support in an ad hoc way to a number of community groups. That is fine of course but as explained in paragraphs 14 and 15 of the Interim Guidance, that is NOT the primary function of the CDW. The key difference is contained in the titles ie a (community) support worker is there to provide support [to individuals] whereas a Community Development Worker is there to help develop the COMMUNITY and support statutory sector services to help them better understand the needs of the communities they serve. So, if faced with conversion of a (community) support worker, the PCT needs to demonstrate that the worker's function has or will be a significant step change FROM working primarily or exclusively with service users TO working at the organisational or strategic layer with a variety of bodies at Chief Executive - Senior Manager level etc.
- if worker X is now to be converted as a CDW, what was their salary level prior to this and what is their new salary level going to be? [Note: the recommended salary level for a CDW is £25K per annum]
- if worker X is now to be converted as a CDW, what part of the E&T Framework as set in the Supplementary guidance have they already received and what elements yet need to be covered? In respect of the "gaps", the employer should be asked to demonstrate how these will be closed giving details of the courses/modules etc the worker will attend with dates, financial support they are going to provide etc.
- the PCT should also be asked to demonstrate how they are going to meet the "requirements" set out in paragraphs 33 to 37 of the Interim Guidance (on support and management).

SUMMARY

5. It is clear the intention is that CDW posts should be filled by new, additional recruits to the mental health workforce, supported by extra resources. Redeploying an existing worker who is working with the BME community should not be regarded as the norm (ie there should not be wholesale conversion in an attempt to meet the target).

Appendix F

INVOLVING SERVICE USERS IN THE DEVELOPMENT OF COMMUNITY DEVELOPMENT WORKERS

Broad range of ways of getting involved

1. The responsibility for engaging with service users and carers should lie with the organisation. This means that you need to be proactive in your approach, reaching out to diverse groups of individuals and communities, and using different methods to engage people.
2. Service users and carers should have access to different ways of becoming involved, as a result of their desire to use their experience. They could become involved in training and developing the capacity of staff in programmes to reshape provision and support development, including research and in the governance arrangements for all programmes.
3. There needs to be a broad range of methods for involving people from:-
 - one-off informal events (eg open space events, conferences, focus groups);
 - to a more sustained involvement in a programme of work (as a team member, providing expert input, as a member of a steering group etc.); and
 - to becoming actively involved in the governance agreements (as a member of a programme board etc).
4. There needs to be an emphasis on building capacity and ensuring that treatment is meaningful. This means providing people with a structured, appropriate induction through information and a welcome process;
5. Being clear about what people need to participate fully, identifying how they want to become involved and reviewing how their involvement is working out.
6. An over-reliance on formal meetings needs to be avoided; engaging with local groups, going to where service users and carers meet, mapping local community organisations, informal social events, holding more formal meetings at the end of a more inclusive and informal meeting and finding ways of 'tapping into the day to day lived experience' of service users (including broadening the diversity of the groups involved).

Practical and emotional support

7. People need to find it easy to participate and this can be done in several ways:
 - An introductory session particularly targeted at service users, perhaps on their own premises, day centres, meeting places etc;
 - Avoiding the use of jargon;
 - Meeting in accessible venues (time, place, formality);
 - Administrative/information support targeted particularly at service users;
 - Allocating a budget in every programme to support targeted particularly at service users;
 - Allocating a budget in every programme to support service user involvement;
 - Advocates or buddies;
 - Staff with responsibility to provide support or access to appropriate support;
 - Clear and accessible information; and
 - A payment policy.

Local networks

- Engaging with local service user and carer groups is important, but it is equally important to find ways of engaging with service users who are not part of a formal group or network
- Supporting and engaging with information networks which connect local service user and carer groups to services

Encouraging service users to apply

8. It is important to try and encourage service users who have experience and desire in the field of mental health and supporting communities to apply for CDW posts. Below is outlined how that may be done:

- Open sessions particularly targeted at service users;
- Outlining the support to be offered to service users who wish to apply;
- Encouraging a support network service for users that involves mentoring and support both formal and informal from interested stakeholders within the community;
- The provision of ongoing training and support; and
- Bringing additional support from NIMHE and other service user based organisations.

Supporting Materials

9. There are a variety of supporting materials about service user involvement and these include:-

- Together - working for wellbeing: “Service-users Together – A guide for involvement”: contact - Pavilion – www.pavpub.com
- Hull and East Riding Community Health NHS Trust: “Service Advisor Starter Pack” : contact – diane.heywood@herch-tr.nhs.uk
- Mental Health Foundation: “A Fair Day’s Pay – A guide to benefits and payments for service user involvement” : contact – www.mentalhealth.org.uk
- Department of Health and Care Services Improvement Partnership: Reward and Recognition – The principles and practice of service user payment and reimbursement in health and social care – A guide for service providers, service users and carers: contact – www.dh.gov.uk/publications

Appendix G1

CAMHS: CITY OF PLYMOUTH CDW FOR THE EARLY YEARS COMMUNITY MENTAL HEALTH TEAM:

JOB ADVERTISEMENT

PLYMOUTH PSYCHOLOGY SERVICE COMMUNITY DEVELOPMENT WORKER FOR BLACK AND MINORITY ETHNIC COMMUNITIES Temporary to April 2007

We are looking to appoint an enthusiastic and highly motivated person to join in the newly created government funded multi-agency Early Years Community Intervention Team. The role of the Community Development Worker is to work across the city of Plymouth with local black and minority ethnic (BME) communities to promote positive early years mental health and the psychological well being of babies, young children (0-7) and their families.

The successful applicant will need:

- At least 2 years experience of working with or for BME communities relevant to the post.
- Experience of working with people who are distressed or displaced.
- Ability to work as a member of a multi-agency team.
- Ability to deliver training on black and minority ethnic issues.

The applicant will have a good general education and demonstrate the ability to learn and apply knowledge.

Appendix G2

**CITY OF PLYMOUTH CDW FOR THE EARLY YEARS COMMUNITY MENTAL HEALTH TEAM:
JOB DESCRIPTION AND PERSON SPECIFICATION**

CITY OF PLYMOUTH

DEPARTMENT FOR LIFELONG LEARNING

JOB DESCRIPTION

JOB TITLE AND GRADE: Community Development Worker for Black and Minority Ethnic Communities – Early Years Community Mental Health Team

DEPARTMENT: Lifelong Learning

SERVICE: Plymouth Psychology Service Early Years Psychology Team

RESPONSIBLE TO: Principal Educational Psychologist

MAIN PURPOSE OF JOB:

To ensure full participation and ownership in the development of positive early years mental health and psychological well being with Black and Minority Ethnic Communities (BME), delivered through the Comprehensive Community Child and Adolescent Mental Health Strategy (CAMHS).

Management Areas and Key Relationships Links with:

- Children’s Centres, Early Years Settings (maintained & non-maintained) and Early Support.
- GP Practices, Health Visitors and Maternity Services.
- Mainstream Mental Health Services and Primary Care Services
- Social Services and voluntary agencies.
- Work with Mental Health Matters Development Worker and the MIND ‘Women of Colour’ worker.
- To link with the Black Workers Support Groups

Job Purpose/Summary

- To work as a member of the Early Years Community Mental Health Team to disseminate a programme to support the psychological well being and emotional development of young children (0-7) from BME communities at both the preventative and early intervention stages
- To work across the City of Plymouth to cover diverse and dispersed communities.
- To give advice and support to health, education and social services on migrant and refugee health issues for young children and their families.

- To provide ongoing identification, quantification and needs assessment of vulnerable groups, currently asylum seekers, refugees and other migrant ethnic minority groups.
- To facilitate access to services available and promoted through the Early Years Community Mental Health Team for vulnerable groups such as asylum seekers, refugees and other migrant ethnic minority communities.
- To provide information and facilitate delivery of appropriate training for health, education, social services professionals and other key organisations in cultural awareness, issues specific to the communities being served and general issues on asylum seekers and refugees in order to gain the confidence, respect and trust of the BME community
- To work in partnership to enable the development o
- To facilitate information sharing and collaboration between health, education, social services and voluntary sector with influence of strategic change when appropriate.
- To encourage use of interpreting services as necessary
- To promote positive Infant Mental Health, Psychological Wellbeing and anti-stigma work in BME communities.
- To flexibly work/adapt local strategies to improve services for BME communities.
- To review current services, identify needs and ensure the development of new and innovative approaches which will improve culturally and linguistically sensitive services that improve access to Community CAMHS programmes for children and their families.
- To work in partnership with Community CAMHS, education and other key organisations to enable the development of knowledgeable staff within the service that have training, skills and attitudes to gain the confidence, respect and trust of the BME community.

CITY OF PLYMOUTH
DEPARTMENT FOR LIFELONG LEARNING
PERSON SPECIFICATION
POST: COMMUNITY DEVELOPMENT WORKER

SALARY SCALE:

	ESSENTIAL	DESIRABLE
EXPERIENCE AND JOB KNOWLEDGE	<ul style="list-style-type: none"> - At least 2 years experience working with or for communities either in the voluntary or statutory sector, including experience of working with the community groups relevant to the post. - Experience of working with people who may be distressed/displaced. - Experience of facilitating the delivery of training and making information available to a range of professionals. - Experience of working collaboratively with a range of agencies. - Experience of carrying out needs assessment and preparing action plans. - Ability to develop, deliver and evaluate training on BME issues, service provision and developments. <p>Ability to demonstrate:</p> <ul style="list-style-type: none"> - Knowledge of the community groups relevant to the post, including excellent awareness of cultural, social and health issues. - Knowledge of any language spoken by the various community groups relevant to the post. - An informed and practical view of the role of a health advocate, including the public/health promotion aspects of the post. - Knowledge of community support and development. 	<ul style="list-style-type: none"> - Experience of working as part of a dedicated service for children and families. - Knowledge of working with parents/carers, babies and young children. - Knowledge of the Community Child and Mental Health Service (CAHMS) agenda. - Knowledge of health and education services available to children and families.
JOB RELATED ABILITIES	<ul style="list-style-type: none"> - Ability to communicate clearly and effectively, both verbally and in writing across various contexts and organisations. - Flexible approach and ability to work independently and on own initiative. - Ability to deal with complex issues facing vulnerable groups in the community - Good organisational and interpersonal skills. - The ability to work with a range of people in different settings, including professionals from statutory and voluntary organisations and members of the public. - Ability to work independently and organise own workload. - Ability to work across a range of organisations and stakeholders. - Ability to help design, deliver and evaluate training on BME issues, service provision and development. - To identify learning needs and undertake agreed training and development in connection with the role. - Access to transport in order to travel. 	<ul style="list-style-type: none"> - Experience of using IT (word processing, e-mail and the internet).
OTHER FACTORS	<ul style="list-style-type: none"> - A willingness to travel in order to observe excellent and innovative practice in other areas of the country. - A willingness to accompany the Team Manager in meeting with National Child and Mental Health Service (CAMHS) community based projects. 	

QUALIFICATIONS	Good general education and a demonstrable ability to learn and apply knowledge.	Preparedness to undertake relevant training and CPD.
PHYSICAL REQUIREMENTS		

Appendix H

CSIP/NIMHE SOUTH EAST DEVELOPMENT CENTRE TOOLKIT

RELEVANT EXTRACTS

Acknowledgements

1.1 This Implementation Toolkit has been produced to assist managers with the localised implementation of the CDW worker role as well as more specific guidance on the career development.

1.2 It is based on an idea by **Keith Bell**, Workforce Development Manager Mental Health Surrey & Sussex SHA and the work has been overseen by **Poppy Jaman**, CSIP - South East (SE) DC lead for Race Equality.

1.3 Many of the 'live' examples within this Toolkit have been provided by colleagues across the Health & Social Care Community in the SE Region, in particular Oxford PCT who have managed to implement a full time CDW and we would like to thank all those who contributed.

Introduction

2.1 This document is intended to act as a guide to the successful implementation and development of the CDW. The implementation of the CDW in the SE region has identified some specific areas that must be considered when implementing the CDW into local services, particularly in respect of recruitment and retention:

Recruitment

- Service planning and development
- Understanding the role
- Identifying the right profile
- Supervision and mentoring
- Management
- Preparation

Retention

- Cost effectiveness – salary/profile
- Career pathway – pay, training and CPD, knowledge
- Job evaluation
- Practice values

2.2 As in all walks of life, some professionals will be content to remain with their existing role, providing a service and making a difference and therefore may not feel the need to move on to other areas of work.

2.3 Whatever career path or progression a CDW might choose, they need to be committed to and take personal responsibility for their own continuing personal development that should include supervision and annual appraisal. The world of health and social care is dynamic, and CDW must fully embrace such change and diversity based on continually up-dating their knowledge and skills.

2.4 The work undertaken through the CDW role should be regarded as one part of the local action responding to the identified mental health needs of BME communities. A coherent strategy for participation of the various stakeholder groups in BME mental health services should be devised, having a particular focus on BME service users and carers.

2.5 The participation strategy could cover such areas as:

- Shaping the role and function of CDW roles
- The most appropriate host organisation to employ a CDW
- Practical arrangements for the location and support of CDW's
- Mechanisms for accountability of CDW's to BME communities
- Identification of BME community concerns and gaps in local services
- Focusing down on immediate steps for improvements in services
- Plans to implement improvements in a participatory way
- Assisting the CDW to be effective in monitoring and evaluating service quality for BME communities

Value Base

3.1 Put simply, the CDW worker value base is around meeting the needs of service users, which pay attention, respect the wishes, and aspirations of service users to lead as ordinary lives as possible. This value base and underpinning skills would include the ability to:

- Listen and communicate
- Talk, demonstrating good communication skills including effective report writing and case note writing, documenting reviews and letter writing
- Spend time with the service user being empathetic, compassionate and patient
- Deal sensitively with distress, disturbance and unpredictability
- Be non-judgmental and versatile in approach
- Be accessible and flexible in availability
- Think and act calmly
- Demonstrate a good understanding of mental health issues
- Show a creative and imaginative approach to problem solving
- Have the practical skills to aid daily living and be prepared to assist with basic practical skills
- Promote the rights, responsibilities and recovery of service users
- Engender empowerment and well-being
- Acknowledge diversity and promote anti-discriminatory practice
- Maintain confidentiality
- Promote safe working practices
- Promote equal opportunities and ensure service users are treated with dignity and respect as part of ethical practice.

3.2 This value base and underpinning skills mirror the Ten Essential Shared Capabilities.

Process

4.1 Preparation prior to implementation of the CDW worker an awareness raising campaign needs to be carried out to all stakeholders. This will help avoid misunderstanding and manage expectations within the PCT and the community it serves. This is particularly important when recruiting a new role for the first time or deploying the CDW to new areas.

4.2 When preparing for the recruitment of the CDW worker, it is important to work towards a timeline so that the process incorporates a period of induction to the trust and preparatory work prior to commencement of the actual daily workload of the CDW.

4.3 The following is a brief Synopsis of the BME CDW Post in Oxford.

Early Implementation Site: Oxford City PCT

Local Context

The concept of the CDW arose from a piece of research that was undertaken between October 2003 and January 2004 in the city of Oxford. The research process involved holding a number of workshops and focus groups to gauge the opinions of the stakeholders, on how to improve mental health service provision for the BME communities in Oxford.

There was widespread attendance from both the statutory and voluntary sector and involvement from service users.

In summary the findings were very much in tandem with the findings found throughout the country, such as:

- Low awareness amongst BME groups of mental health services
- High proportion of BME groups being admitted as a direct result of detention under the MH Act
- High use of mental health services at a very acute stage
- Very low trust and confidence found amongst BME groups around the statutory MH services

The total black and ethnic minority population of Oxford City is 12.5% of the whole population (approximately 25,000 people) in the following proportions:

- Asian 38%
- Black 19%
- Chinese 14%
- Mixed 19%
- Other 10%

The focus of the workshops was to exchange information about work which was already taking place and to agree a way forward in developing and improving services for black and ethnic minority service users and their families and carers.

It was acknowledged that Short term funding for community projects contributed to a lack of forward momentum and a slowness to make positive changes which inevitably could result in a long term impact on improving service provision and experience for BME groups.

A number of community groups in Oxford deliver mental health services without the developmental support or useful links with statutory services, such links if made, would facilitate feedback from BME communities to service providers and commissioners and improve access to services through primary care.

In acknowledging these wide ranges of issues, the PCT agreed to recruit a community development worker who would work with communities to build capacity and confidence amongst them and also prime mental health service providers of the major obstacles faced by BME groups whilst accessing mental health services.

The fact that the majority of BME service users came into contact with mental health services at a very acute stage prompted the PCT to look at improving access to mental health services at a primary care level.

This therefore hypothetically meant that not only would we have better service provision, but also result in a more engaged and better informed community.

For this piece of work Oxford has been marked as an early implementer site, to become a model of good practice for the rest of the country by the NIMHE for the implementation of the CDW post.

The Thames Valley area has had an allocation of 17 CDW's to be in post by the end of 2006. The funding for this has been allocated in baseline funding for PCT's according to the DH.

Although here at Oxford we are working closely with the Thames Valley SHA Race Equality Advisor, to identify ways in which this funding can be accessed, and also ways in which the CDW initiative is linked into the Race Equality Scheme for the PCT

Wider support for this work is also being provided by the regional Race Advisor at the South East DC for NIMHE.

The role of the CDW is part based on three building blocks identified in the Delivering Race Equality paper which are:

1. More appropriate / responsive services

2. Community engagement / capacity building
3. Better information and awareness

The rationale for this is to get it right for the most vulnerable and least engaged communities first and then this same model can be used to improve the services for the rest of the groups.

The work of the CDW would help achieve the following outcomes for the BME communities:

- Sustained community engagement
- Increased community understanding of mental health issues and services
- Increased capacity within local community support groups
- Increased awareness and better use of primary care services
- Clients receiving the most appropriate interventions, support and information in primary care and improved access to secondary services

Management structure

The CDW will be managed through Oxford City PCT, with direct line management responsibilities with the Head of Mental Health who is based in the Service Redesign and Commissioning Directorate.

The fact that the CDW is part of the service redesign directorate will not only assist improved engagement with the BME communities but also provides a mechanism for providing actual change as part of the service redesign process in mental health service delivery.

The CDW will be physically based in a health centre which is also the base for the health advocates for BME communities, it is ideal for providing a primary care setting for the CDW to work from in order to be closer to the very communities the post holder wants to engage with.

The Race and Mental Health Partnership Group (Rampag) will provide the overall strategic direction for the work of the CDW, with a proposal being put forward currently to have a subgroup set up, with a specific remit on the work of the CDW. Rampag is a multi agency partnership group that focuses on race and mental health issues, and is directly accountable to the Mental Health Task Force which is the Oxfordshire-wide Local Implementation Team.

This will therefore not only ensure direct accountability lines for this piece of work, but also direct ownership amongst the wider Local Implementation group that has responsibility for driving forward the mental health work programme.

In Oxford the Tavistock / Oxfordshire Mental Healthcare NHS Trust (Isis centre) undertook a Diversity project in collaboration, this included current mapping and assessing the needs of BME communities in relation to mental health. As a direct consequence of this piece of work, we will be using the recommendation to inform direction of work for the CDW.

In terms of actual support mechanisms being set up for the CDW, we will work with the MH Trust and voluntary sector to implement the recommendations of this report which call for the following:

- Establishing a Learning Set for all BME workers in Oxford working in mental health, these workers will include both statutory and voluntary sectors representatives.
- Creating “Thinking Spaces” for all the mental health trust staff, what this would entail is setting up a forum or drop in session where staff would attend and discuss issues around race and equality in a non-formal environment, as well as having key speakers attending from time to time.

The thinking behind the Learning Set idea is to provide a support forum for all BME staff working in isolation in mental health and mental health related fields, for them to have the opportunity not only to learn and disseminate good practice but also to identify and convey issues of concern. The facilitator of the group would then report back to the Race and Mental Health partnership Group (Rampag) to provide feedback from the group sessions.

The “Thinking Spaces” forums would be divided into two categories:

- Internal mental health trust staff

- External wider mental health staff

The internal group would give employees of the mental health trust an opportunity to meet and discuss issues pertaining to race and mental health, and also provide an opportunity for staff to be educated and informed about various issues that affect BME service users.

The external Thinking Spaces forum would allow anybody working with BME service users to again meet and discuss this group would encompass all statutory and voluntary organisations. Thus providing educational awareness for the wider group of workers who work with BME service users either directly or in-directly.

So the overall outcome would not only ensure positive change occurs in service delivery via the CDW, but also change in organisational culture and professional attitudes is initiated by providing the information and educational awareness to staff working with BME service users.

Recruitment

The job description and personal spec for this post was developed in partnership with all the key stakeholder agencies and wider consultation for this was done at the quarterly Rampag meetings, which is also attended by the SEDC regional Race Equality Lead.

The post was advertised very widely in the following settings:

- Guardian Society
- PCT vacancy bulletin
- Mailed out directly to the voluntary organisations in Oxford
- Put on community development networks online nationally
- Emailed across to colleagues elsewhere in the country

This ensured the widest possible exposure of the advert to the very people we wanted to attract to this post. In all we had over 57 people requesting further information about this post and as a result we received 19 applications in all.

Of the 19 applications that we received 6 individuals were short listed for an interview process. We were very keen to get the right person for this post and therefore had to adhere quite strictly with the criterion that was set.

The interview panel consisted of representation from the following:

- PCT
- Voluntary sector
- SHA Race Lead
- MHTrust
- Service user

The interviews were held, although we were not successful in recruiting somebody on that day we did have one candidate who was unable to attend. This person was given an opportunity to attend an interview at an alternative date, he was successfully recruited.

Lessons Learnt

- In terms of recruiting the CDW it was quite apparent that although the advert for the post created a lot of interest, it did not however mean we were appealing to the right calibre of candidate. We had thought of a contingency plan in case we were unsuccessful, whereby we would have identified local individuals who would have then been trained, and their capacity built for them to carry out the role of the CDW.
- The individuals identified in the contingency plan were predominantly those working within the voluntary sector who could then have been encouraged to apply for the CDW post, but initially in a trainee capacity.
- In areas earmarked for the community engagement projects, the recruitment of volunteers or those individuals providing sessional support to these projects would be ideal candidates, serving as fertile ground for identifying potential CDW's in these areas.

- We also found that it was important to do a trail of all the BME led projects in the area to identify possible overlaps or duplication of the work of the CDW. An example of this is where locally in Oxford the voluntary sector were about to recruit somebody, to carry out a similar role to that of the CDW, this would have resulted in duplication of two similar roles.
 - In terms of the partnership approach pursued, we have from conception to the actual interviewing process included key stakeholder representatives that have included the voluntary sector, service user involvement, social care representation, PCT representation and the local mental health trust being represented throughout the project.
- This partnership approach has ensured we attain rightful ownership of this project throughout the mental health community.
- We found that more support was required from NIMHE to ensure the current PCT baseline funding allocation for the CDW post's is identified in order to initiate the recruitment of the 4 more CDW post highlighted for Oxford.

Recruitment

5.1 The new CDW worker requires 3 forms of support: Supervision, Mentoring and Management.

- Manager to provide normal day to day employee management – pay, sickness, discipline, performance
- Mentor to provide health service and mental health guidance and advice and to support those elements covered as part of their training
- Supervisor to provide clinical supervision for that activity carried out with patients and clinical theoretical work provided by the training course

Example Job Advert 1: Oxford City PCT

Looking for an Exciting Opportunity?

Black and Ethnic Community Development Worker - Mental Health BME

We are looking for a committed, enthusiastic, dynamic individual who is fully on board with the user empowerment agenda to support people from black and ethnic minority backgrounds in dealing with mental health and mental ill health to realise their potential, have a say in their lives and improve the development of services in the county.

The successful candidate will be expected to apply for a Standard Disclosure from the Criminal Records Bureau as the post involves working with vulnerable adults.

Example Job Advert 2: Birmingham & Solihull Mental Health Trust.

Developing plans to expand the Forensic Directorate to provide additional beds for men requiring secure mental health care. Part of this process is to carry out a public consultation of the proposed services and engage with the community regarding service development.

As a consequence an exciting opportunity has arisen for a secondment into a Community Development Worker (CDW) role. Initially this post is for 6 months but there is an opportunity for this to be extended for the life of the project if funding becomes available.

The post holder will work as a key member of the Third Male Medium Secure Unit Project Team engaging with the local community, providing a resource and supportive link between the community and mental health services in proximity to the proposed medium secure service in Small Heath.

Based on guidance from the Department of Health the CDW will be required to: -

- Work within the local community, exploring and creating an in-depth understanding of the population, local community organisations and agencies and the nature of the economic and educational status within the community;
- Develop sound working relationships with members of the community from all sectors (BME and White Ethnic backgrounds), including key leaders to establish a range of communication networks;
- Raise awareness of generic and forensic mental health issues;

- Share information widely regarding the new service developments;
- Promote BSMHT as a service provider and employer.

The successful applicant must have a sound understanding of mental health issues, have previous experience of working and living within diverse populations, have experience of working with people with mental health problems, and be able to speak more than one language pertinent to the community in Small Heath

Appendix I

SANDWELL PCT – SYNOPSIS OF CDW DEVELOPMENTS

Introduction

1. Sandwell is looking at ways in which to address the CDW agenda by examining existing resources/staffing within community organisations in the Borough. The following points provide a synopsis of the model that had been developed with CDW education and training, and ideas about career development requiring further planning.

How the CDW target was met

2. There were originally 4 CDWs to be assigned to the Sandwell borough, but extra resources were located internally to provide a CDW coordinator in addition to this target, making a total of 5 staff.

How innovative the work is that is being developed

3. The main innovative aspect was the way in which the CDWs would have been linked in with effective existing structures. In Sandwell, there is a Community Health Network (CHN) with a remit around the improvement of the health and wellbeing of BME communities in the Borough, with one Health Development Officer assigned to work with each of the following communities: Indian, Pakistani, Sikh, Bangladeshi, African Caribbean and Yemeni. These six workers are based at organisations that provide services to these communities, and work to a well-established community engagement model. The idea was to build on this existing engagement with the addition of CDWs to add the needed MH element. The CDW coordinator would have been line managed by the same person that manages the CHN, and the CDW team would have attended the same staff meetings as the CHN, linked in with their programmes of work, and utilised existing links as a way into engaging with communities around mental health issues.

What model has been developed and how does it related to the National CDW guidance?

4. The model of delivery consists of a team of 5:

- 1 CDW coordinator
- 1 CDW (male) with a lead role for the Pakistani Community
- 1 CDW (female) with a lead for the South Asian Community
- 2 CDWs with generic roles to ensure engagement with a wide range of communities including eg refugees and asylum seekers within the deaf community

5. The model relates to national guidance in that it is built upon an understanding of the local population in terms of ethnicity and language, with the capacity to address prioritised local issues and also provide a long term inclusive service to all BME communities in the Borough.

How does the model meet the inside and outside approach in developing services to BME communities?

6. The model addresses the 'inside' in that the CDW team would be employed by Sandwell PCTs, and the co-ordinator in particular would therefore have access to and influence with commissioning process and ensure the work of the CDW ties in with local MH strategy. The model addresses the 'outside' in that the CDW team would be based within a community organisation in a central location, and as mentioned previously would link in with existing community organisations and structures.

How and what tools are being developed to evaluate the work of the CDW and measure outcomes and outputs which lead to critical success factors?

7. The CDW steering group, comprising relevant stakeholders, would set objectives and priorities and ensure the ongoing monitoring and success of the CDW team. In addition all community development programmes would report to, and be evaluated through existing PCT/Community Network mechanisms. Contact: Lesley.brougham@os-pct.nhs.uk

Appendix J

BME Community Development Worker (CDW) Audit Tool – “How to tell if it counts”

[developed by Cumbria and Lancashire SHA in conjunction with Northumberland, Tyne and Wear SHA]

Introduction

This Audit tool has been designed to:

- Help Commissioning Organisations (PCTS and Care Trusts) decide whether the BME Community Development Workers they are commissioning fulfil the DH guidance and criteria and are able to be counted towards the 31 December 2006 target figures for each primary care organisation.
- Help the Strategic Health Authority in performance managing delivery of the target.
- Assist employers in understanding the role and function of their CDWs, monitoring their effectiveness and help identify development needs
- Help CDWS themselves better understand their role and function
- Enable local health Communities, Focused Implementation Sites and the SHA take a more strategic view of CDW activity and facilitate the development of an effective SHA wide network.
- Help local BME communities recognise the difference that the CDWs are making to improving the health and well being of local communities.

How to use the audit tool

The tool offers a framework for the PCT to use focusing on two aspects:

- The organisational arrangements
- Role and function of the CDW

For each of these two aspects there is a short pro forma to be completed for each CDW post.

There are three columns:

Column 1 – Takes the key criteria from DH guidance** and suggests how these can be measured.

Column 2 – Suggests how this might be measured

Column 3 –Is for the PCT to complete

*(**The primary source of the DH guidance is.- “ Community Development Workers for BME Communities: Interim Guidance – DH Dec 2004” CDWS for BME Communities – Education and Training –Supplementary guidance October 2005; and CDWs for BME Communities ; Redeployment of existing workers CSIP/NIMHE 31.10.05;)*

The PCT should complete a pro forma for **each worker** to satisfy themselves that the role meets the DH criteria. A copy should be sent to the *SHA Mental Health/Performance Management Lead* as evidence that the role is being fulfilled.

It is accepted that in many cases CDWS will be new in post and not all of the evidence will be available that they are fulfilling the full role and function – nevertheless the organisational arrangements and job description should be able to provide the evidence that the post has been designed to fulfil the policy requirements.

In addition to the above guidance PCTs may find it helpful to use the Implementation Guidance produced by Cumbria and Lancashire SHA *(please contact Sara Taylor on 01772 645702, email sara.taylor@clha.nhs.uk for a copy of this document)*

PCT name:	W.t.e.:
CDW name:	Date in post:
Employed by:	Salary/(Agenda for Change Banding if applicable):
Please can you briefly state why CDW is employed by this organisation (e.g. PCT chose to commission from NHS Trust, Voluntary organisation etc).	

Part 1 Organisational Criteria

Criterion & guidance ref	How measured	Answer
Has this post been commissioned and funded by the PCT?	Funding and contract between PCT commissioner and CDW's employer	
If not commissioned by PCT, by whom and how does this clearly link to local implementation of the DRE policy?		
Is this CDW – dedicated... senior...., specifically focused on improving Mental Health and social care services by working with the community.	Evidence from job description; evidence of seniority e.g. A for C band 5 or 6.	
Not an existing support/development worker trying to do the CDW role in addition to their present role.	How is the CDW part of their work clearly distinct from their other role? What portion of time will they usually spend as a CDW?	
How is it a real step change from working primarily with service users to working at organisational or strategic level with Chief Execs and Senior managers?	How will the PCT ensure that each worker will influence the planning and development process to meet the identified needs of their BME communities?	
What education have they received and what plans are there to put this in place? (Paragraph 45-49 of Interim Guidance)	Has an analysis been carried out of the education and training they will need? What plans are there to do this and how will education and training be provided and by when?	
How is the PCT meeting the requirement for support and management? (Paragraph 33-36 of Interim Guidance).	Is there a senior manager in place to ensure that appropriate arrangements are in place for support, supervision and operational management?	

Part 2 Role and function

This section is designed to ensure that the CDW is covering the “Four key roles of CDWs” as set out in Appendix A. It should help in understanding outcomes – e.g. what difference there will be, (particularly what will the BME community see) as a result of this new role?

Key role – Change Agent

Criterion	How measured	Answer
How will this person identify community concerns and gaps in service?	In job description: CDW has developed effective networks with appropriate organisations	
How will this person seek out the capabilities of communities to develop and support innovative practice?	In job description: CDW has identified and formed links with key stakeholders	
How will this person increase channels of communication between community and statutory services?	In job description: CDW has developed effective links with appropriate organisations	

Key role – Service Developer

Criterion	How measured	Answer
How will this person develop joint working between statutory and community services?	In job description: CDW has developed effective links with appropriate organisations, and can provide evidence of effective partnership working	
How will this person advise on training and education of staff?	In job description: CDW has established route to feed views to senior manager/CDW network.	
How will this person highlight the importance of culture in service systems and practice?	In job description: CDW has developed effective relationships with service partners so he she can effectively promote the importance of culture; employer has systems in place to facilitate this.	

Key role – Access Facilitator

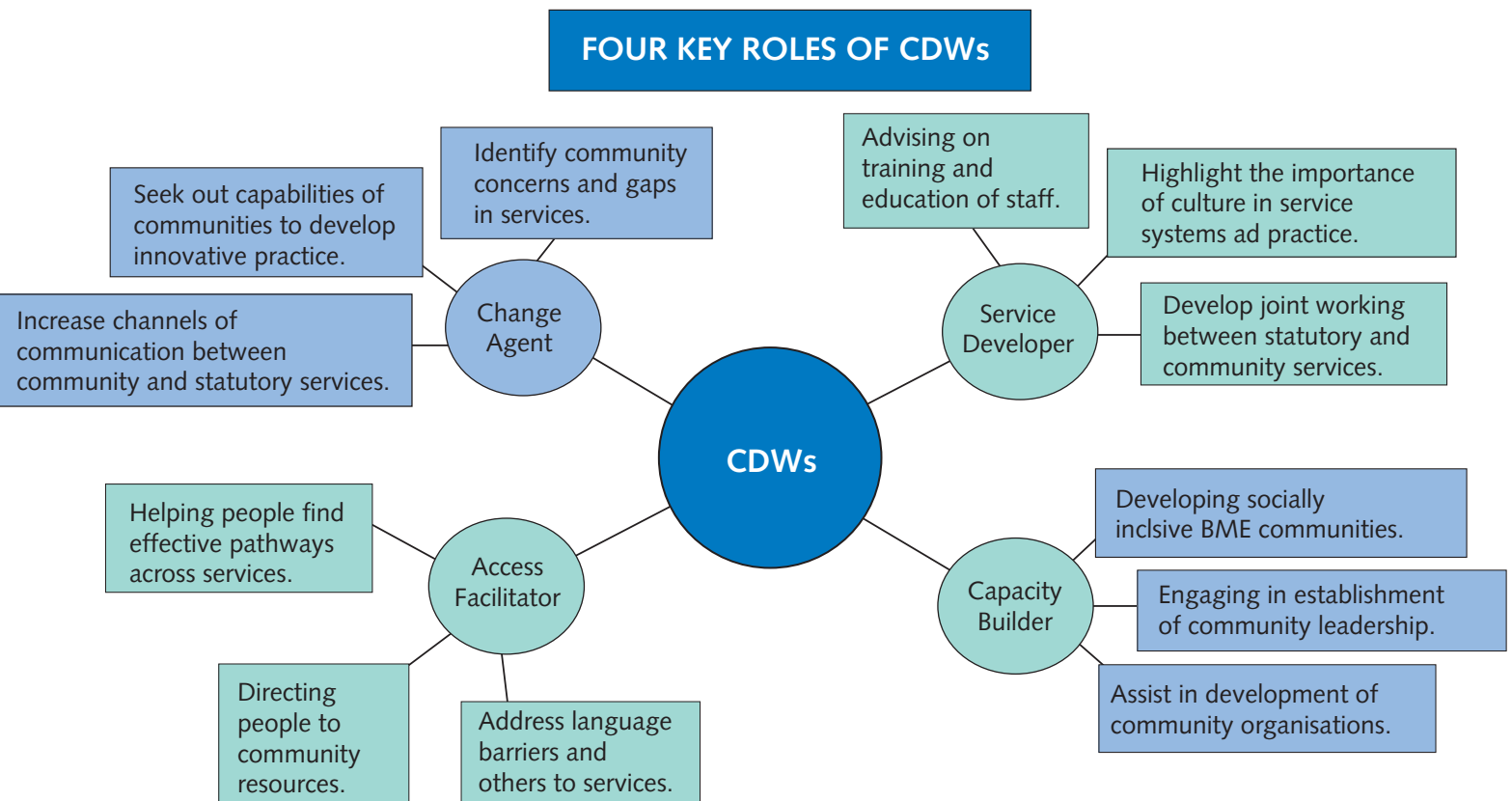
Criterion	How measured	Answer
How will this person help people find effective pathways across the whole range of statutory and non – statutory services?	In job description: CDW can provide evidence of how he/she has helped people progress through service e.g. Service User surveys	
How will this person direct people to community resources?	In job description: CDW has developed effective links with appropriate organisations and networks	
How will this person address barriers to access e.g. language barriers?	In job description: CDW has developed effective links with appropriate organisations and networks	

Key role – Capacity Builder

Criterion	How measured	Answer
How will this person support the development of community organisations?	In job description: CDW has developed effective relationships with local organisations and understands the routes and systems that can be employed to facilitate this.	
How will this person engage in establishing community leadership	In job description: CDW has developed effective relationships with local organisations and understands the routes and systems that can be employed to facilitate this.	
How will this person develop socially inclusive BME communities?	In job description: CDW has an understanding of “social inclusion” within their own local context and how they can contribute towards it’s development within their job role.	

Annex A

Diagrammatic Form set out in Appendix A of the Interim Guidance



Appendix K

Southwark CDW forum – Draft Terms of Reference

Background

- The development of Community Development Workers (CDWs) is part of a wider programme aimed at tackling inequalities faced by BME users of mental health services. Underpinning the initiative is a dedicated person at senior level solely focussed on improving the commissioning and provision of MH services to and on behalf of the BME community by working directly with that community and relevant stakeholders as set out in the guidance.

Aims

- To provide leadership in the process of planning and developing the roles of CDWs including advising on job descriptions and learning from other early implementation sites
- The Subgroup of CCAG (Cultural Competence & Awareness) will be this group's link to board level
- Our overall goal is to oversee the implantation of BME CDWs across the local health and social care economy (e.g. communities, volunteer and statutory sectors)
- To ensure that CDWs and STRs (*Support, Time and Recovery Workers*) workforce targets are met by December 2006

Objectives

- Review and shape the CDW role
- Consider practical arrangements (a) Training – taking into consideration the Ten Essential Shared Capabilities (b) Career development (e.g. pay, training and job evaluation) (c) Line management responsibilities (d) Supervision/mentoring arrangements (e) Relationships with existing workers in similar roles (f) Location
- Ensure a forum for CDW networking and support is in place
- Ensure that CDW's are accountable to BME communities (by linking up with BME Stakeholders)
- Consider ways CDW's can effectively monitor and evaluate service quality for BME communities

- Agree ways that the CDW role could and should be evaluated
- Raise the profile of CDW's and their work
- Developing an action plan for CDWs
- Establishing means to measure progress towards results
- Periodically review progress and where needed seek guidance from CCAG and other partners

Membership

- Open to anyone in the community, voluntary and statutory sectors (who is willing and enthusiastic about this opportunity) and who are able to attend meeting regularly
- Able to provide advice and views on the implementation of BME CDWs
- To take a major part of the responsibility for the professional and managerial implementation of the roles of CDWs
- Willing to engage fully in collective consideration of issues and taking account of the full range of relevant factors, help contribute to the advice given to those charged with the implementation of CDWs
- Working with other community teams involved in supporting the development of a effective programmes that will translate the concept of healthy communities into a practical reality

Exit Strategy

- After the final guidance is published, Stakeholders from BME communities take over the running of the working group
- To lobby for funds to employ CDW's this could include a multi funding base (given our current financial situation this is likely to be a long-term aim)

Appendix L

West Midlands CDW Network

Draft Terms of Reference

Aims

To work towards eliminating ethnic inequalities in mental health and social care, ensuring that service provision in the South West becomes more appropriate, accessible and responsive to the needs of Black and Minority Ethnic (BME) and communities.

Objectives

1. To share good practice and successful community development strategies that can bring about better services for BME Communities, families, and individuals.
2. To offer an information and support network to the many dispersed BME CDWs across the region.
3. To report on the progress and achievement that can be achieved by utilising Community development work in the implementation of 'Delivering Race Equality in Mental Healthcare Action Plans'
4. To provide a central vision and direction in delivering culturally competent health and social care services to BME individuals, families, and communities.
5. To develop a better understanding of the varying organisational cultures that CDWs have to work with and how these can block or enable BME communities across the region.
6. Ensure that the needs and aspirations of BME communities are integral within local and national strategies.
7. To be a central voice for BME CDWs
8. s to highlight what is going well within the region, and what is not.
9. To use the network as place to address some training and personal development needs.
10. To share ideas on how to make care pathways more accessible for people from BME groups, paying particular attention to implementation of effective mental health promotion strategies to facilitate engagement of hard to reach groups.
11. To support and enable the future recruitment and retention strategies for BME CDWs in SW.

Appendix M1

West Midlands Senior CDW Role

[Personal explanation]

1. My name is Jackie Latty and I currently work in the role as the Service Lead for Race Equality and Transcultural Services based in the Asian Community Mental Health Team in Coventry. My role was designed to develop and put in place a framework introducing the Delivering Race Equality Scheme across the voluntary and statutory sectors in order to:
 - enable more effective and appropriate MH services for BME people in Coventry;
 - to manage existing targeted MH services in the PCT;
 - to provide a lead in MH service on Race Equality; and
 - to support the broader agenda on equality and diversity.
2. Around 340,000 people form Coventry's responsible population.
3. Within this population, BME representation is approximately 16%, which is higher than the National and West Midlands average. People from a South Asian ethnic origin also make up some 10-11% of this population, making them a significant community in their own right.
4. With this in mind, I have worked closely and strategically with the Operational Manager of MH Services and the Director of MH to plan the way forward for this very important agenda. In Coventry we believe in having open access through service user forums, user reference groups and community awareness events; in order to enable us to get on board and in touch with the needs. I work "Inside", and "Outside", of services in order to build confidence in the community whilst feeding directly into commissioners. I have recently supported some reviews within the voluntary sector and would like to extend this approach by engaging the CDWs in a closer working arrangements in this arena in order to build and influence greater partnerships to support the needs of the service users and their carers.

5. We currently have two CDW'S who are based in the Asian Community Mental Health Team (CMHT) and we have plans to appoint a Band 6 CDW who will support me in leading the work; our aim is to link them into the wider diverse community to ensure that there is inclusion and positive engagement. The CDW's have been attending the Regional CDW Network meetings as I see this as an integral part of their wider learning needs and an invaluable source for reference and networking. The CDW's report to me directly and have started a piece of work around scoping and identifying the range of services within the localities in Coventry.
6. We have recently agreed in Coventry that a part of our vision is to emerge as a FIS and we are soon to become a Buddy FIS site in order to improve access, experience and outcomes for BME communities who come in contact with mental health services.

Contact: Jacqueline Latty – Service Lead for Race Equality & Transcultural Services
Based at Transcultural House, 459 Foleshill Road, Coventry, CV6 5AQ.
Jacqueline.latty@coventrypct.nhs.uk

Appendix M2

Coventry Teaching Primary Care Trust – Outline Job Description

TITLE:	Mental Health Service Lead for Race Equality and Transcultural Mental Health Services
GRADE:	Trust Pay Scale Points 32 to 35, (£30,732 to £34,568)
LOCATION:	City Wide Service
BASED AT:	City Wide Service
ACCOUNTABLE TO:	Director of Mental Health Services
REPORTS TO:	Operational Manager for Community Services
PROFESSIONALLY RESPONSIBLE TO:	Operational Manager for Community Services/Fieldwork Manager for Social Services
LAST UPDATED:	May 2005

JOB PURPOSE:

- To develop and put in place a framework across the voluntary and statutory sectors for effective and appropriate MH services for BME ethnic people in Coventry.
- To manage existing targeted MH services in the PCT during the transition period, namely the South Asian MH Team and the Asian MH Access Project.
- To provide a lead in MH services on race equality and to support the broader agenda on equality and diversity.

KEY RELATIONSHIPS:

Internal	CMHT Leaders, Operational Managers, Other Senior Practitioners across the city, the PCT lead for Involvement and Diversity and the PCT REL
External	Voluntary/other statutory agencies/User Groups

DIMENSIONS:

KEY RESULT AREAS: To effectively:

- Manage a CMHT.
- To manage and co-ordinate Asian MH access project.
- To deliver key targets of a CMHT in accordance with the National Service Framework and Policy Implementation Guidance, lead and support MH with the agenda associated with equality and diversity.
- To act as a resource across MH with regards to BME issues.

The post holder will:

Race Equality

- Consult with service users, community members and staff on a framework for effective and appropriate MH services for BME people in the city.
- Design and secure agreement for a costed and timetabled plan for putting this framework in place.
- Ensure that the plan meets with all recognised best practice, drawing on good practice in all sectors in the UK or further a field.
- Provide line management for the South Asian MH Team and the Asian MH Access Project.
- Ensure a smooth transition from the existing service structure to the new service framework.
- Develop commissioning standards for all voluntary and independent sector MH services targeted at BME communities and develop positive partnership arrangements for ensuring effective delivery.
- Advise on commissioning standards for all external MH services funded by the PCT to ensure high standards of care and treatment for BME service users.
- Coordinate the work on Equality Impact Assessment in MH services, liaising closely with the PCT's REL.
- Support staff and managers in promoting race equality in PCT MH services.
- Liaise with BME user and carer groups to ensure that they are involved in and able to influence the planning and delivery of MH services.

- Support staff and managers in implementing the broader agenda on equality and diversity, working closely with the PCT Lead for Involvement and Diversity.

General Management

- Provide clear supervision to the members of the multi-disciplinary teams in the performance and fulfilment of their duties to meet service delivery requirements.
- Manage rotas and staffing levels including recruitment across the relevant sector to ensure continuity of the service provision.
- Regularly plan and review the management and development of the service tasks in consultation with the Operational Manager and provide a regular summary of service data and development progress reports.

Financial Management

- Accurately and effectively manage the services budgets ensuring efficient use of resources.
- Manage funding applications for Care Plans and react accordingly.
- Monitor and report amendments to all Community Care Packages and their financial implications for the City-wide Community Care Budget.

Information Management

- Develop and maintain appropriate effective communications systems with all internal and external stakeholders to enhance the delivery of the service.
- Ensure consistent use of caseload management information systems across the sector and work with other Team Leaders to ensure City-wide consistency.

Service Management and Co-ordination

- Ensure effective, regular and recorded meetings of both internal teams and external partnership providing community MHcare in the sector, addressing issues in relation to the delivery of care to clients.
- Develop effective partnerships with other statutory and non-statutory organisations and support inter-agency working to improve the service delivery.
- Ensure effective liaison with General Practitioners and general health Primary Care Teams in the sector to provide practitioner – to – practitioner support and guidance in relation to mental health and the shared management of referrals of clients to the Primary Care MH Team.

Development of Community MH Services

- Seek the views of clients to continuously improve services to meet the future needs of the clients.
- Work with the Field Work Manager to inform clients and client groups of service development plans and progress.

Work with the Operational Manager for Community Services and the Field Work Manager

- Supply the Operational Manager with all necessary information relating to the delivery of CMHT/AMHAP in order for them to be able to conduct their job effectively.
- Assist the Operational Manager with the investigation of complaints or untoward incidents to ensure learning outcomes are implemented.
- Assist the Operational Manager and Field Work Manager in implementing objectives arising from local and national reviews and policy guidelines and the Clinical Governance Agenda and Social Care Agenda.
- Inform the Operational Manager of any sector issues felt relevant to the operational management and development of services.
- To support the Field Work Manager in the co-ordination of the Community Care Budget to ensure efficient use of resources.

Clinical and Social Care Activities

- Manage and support the Duty Desk to ensure the service is being delivered in accordance with the current service model.
- Provide limited participation in the Duty Desk Service.
- To provide support to Service Leads to “problem solve” matters arising in relation to MH Act Assessments, Approved Social Worker (ASW) responsibilities, Guardianship Panel and other legal issues as required.
- Monitor, evaluate and improve the quality of care throughout the sector by implementing Clinical Governance recommendations.
- To supervise the effective chairing, planning and recording of Care Conference Reviews and other clinical meetings.
- Ensure that clinical governance is seen as a core day-to-day feature of the working practices of all members of the teams.

Training and Staff Development

- To provide effective management and leadership development of their teams in their managerial and clinical areas of responsibility in order to ensure continuous improvement of employees, as well as the service.
- To ensure the teams provide appropriate mentorship, guidance and supervision to all individuals in the community teams in their sector.
- Conduct and participate in Individual Performance Reviews (IPR) for the Service Leads.
- To ensure that they conduct regular appraisals for all staff and complete personal development plans appropriate to their requirements and the needs of the service, and that these are delivered.

General Responsibilities

- Ensure compliance with all Policies, Procedures and Protocols of Coventry City Council and Coventry Teaching PCT, including Equal Opportunities, Human Resources, Health and Safety, Data Protection and Patient Confidentiality.
- Carry out other duties commensurate with the grade of the post, as required by the Operational Manager.
- Act up in the absence of the Operational Manager (as agreed) and to cover for other CMHT Team Leaders in their absence as agreed.
- Commit to working within the Coventry Values Statements.

This Job Description outlines the main duties and responsibilities of the post. Owing to the changing nature of service development, the duties and responsibilities and obligations placed upon post holder will inevitably vary and develop. In view of this, this job description will be reviewed every 6 months and subsequently may be altered in consultation with the post holder

COVENTRY TEACHING PRIMARY CARE TRUST**PERSON SPECIFICATION**

JOB TITLE: Mental Health Service Lead for Race Equality and Transcultural Mental Health Services

DEPARTMENT: Community Mental Health

POST REFERENCE NUMBER..... GRADE...SMP.....

FACTORS A/1	ESSENTIAL High 3	HOW IDENTIFIED
QUALIFICATIONS/ TRAINING		
• <i>Level of education</i>	Management qualification	A
• <i>Professional qualifications</i>	Educated to the equivalent of A level	A
• <i>Vocational training</i>		A
• <i>Post basic qualifications</i>	Evidence of continued professional development	A
• <i>Training and learning courses</i>		A
EXPERIENCE		
• <i>Length and type of experience</i>	At least five years of working in a senior position.	A – I – R
• <i>Level at which experience gained</i>	Experience of leading a team or service. Proven managerial experience. Experience of service development	
SKILLS/KNOWLEDGE/ ABILITIES		
• <i>Range and level of skills</i>	Leadership and supervisory management skills	A – I – R
• <i>Depth and extent of knowledge</i>	Standard setting and auditing	A – I – R
	Budgetary skills	
	Change management skills	A – I – R
	Project management Skills	A – I – R
	Recovery Model of care	A – I
	Mental Health Act 1983	A – I
	Care Programme Approach	

FACTORS A/1	ESSENTIAL High 3	HOW IDENTIFIED
SKILLS/KNOWLEDGE/ ABILITIES (cont)		
	Mental Health Policy implementation Guides	A – I
	Awareness of national and local policy and the implications for service delivery	A – I
	Clinical Governance and Clinical Supervision	A – I
	Best Practice	A – I
	Significant knowledge of the issues around the BME communities.	A – I
	Up to date knowledge of national race equality policy and legislation	A – I
	Understanding of mental health needs in the context of black and minority ethnic cultures (instead of 'Significant knowledge of the issues around the BME communities')	
PERSONAL QUALITIES		
	Lead by example	I – R
	Current Driving Licence	A
	Demonstrate continuous professional development	A – I
	Commitment to equality and diversity in all aspects of work and practice	

FACTORS A/1	ESSENTIAL High 3	HOW IDENTIFIED
CONTRA INDICATIONS		
• <i>The criteria which if present in a candidate would prevent an appointment being made</i>	Demonstration of discriminating attitudes/behaviour	I
	Lack of awareness in relation to mental health problems	I
	Inability to work as a committed team member	I
	Poor record of attendance – in excess of 6% pro rata without reasonable cause	R
	Poor presentation and communication skills	I
	Inflexibility	I

How identified: A = Application form, I = Interview, T = Test, R = Reference

All applicants who declare a disability and meet the essential criteria will be offered an interview

Appendix N1

Agenda for Change banding

JOB MATCHING FORM						
Job ID:						
Job Title:	Community Development Worker (Mental Health) - Black & Minority Ethnic Communities					
Job Statement:						
Profile ID matched to:	Project Manager 6?					
Panel:						
Factor	Level	Sub	Score	Match?	Rationale	Panel Notes
1.Communication & Relationship Skills	4	a	32	m	mental health, in communities, barriers to understanding communication all levels; main purpose = bridging	
2.Knowledge, Training & Experience	6		156	m	specialist in field; mental health certificates. Experience of & understanding institutional racism & multi racial groups	
3.Analytical & Judgemental Skills	3		27	v	analysis if required when supporting communities in dealing with mental health	
4.Planning & Organisational Skills	3		27	v	e.g. planning the development of targeting local needs & hard to reach groups in the community	
5.Physical Skills	2		15	m	if standard driving and key skills are mentioned	
6.Patient/Client Care	2		9		Basic clinical advice	
7.Policy/Service Development	3		21	m	input into service redesign; develop means to reach groups in community	
8.Financial & Physical Resources	2		12	v	Handles small amounts of money? Signatory?	
9.Human Resources	3	c	21	m	Delivering training and development activities	
10.Information Resources	2	b	9	v	Reports?	
11. Research & Development	1		5	m	no R & D	
12.Freedom to Act	4		32	m	work autonomy? Work is managed not supervised; broad guidelines	
13.Physical Effort	1		3	m	Sitting, Standing, Walking	
14.Mental Effort	3	a	12	m	unpredictable work; frequent concentration	
15.Emotional Effort	2	b	11	v	in community working with mental health issues	
16.Working Conditions	2		7	m	driving, VDU?	
			399		Band 6	

Appendix N2

Sample Job Description

This is the Job Description that went through the A4C by Oxford City PCT and was badged at Band 6



JOB DESCRIPTION

POST TITLE:	Community Development Worker – (Mental Health) Black and Minority Ethnic Communities
GRADE:	circa 25K
HOURS:	Full Time (37.5 hours a week) flexible
ACCOUNTABLE TO:	Head of Mental Health, Oxford City PCT
REPORTS TO:	Head of Mental Health, Oxford City PCT
BASE:	East Oxford Health Centre/Raglan House

JOB PURPOSE:

To reduce and eliminate ethnic inequalities in mental health service experience and outcome; to support BME communities in dealing with mental health and mental ill health; to bridge the gap between western models of care and traditional support structures and support early intervention and access to primary care services.

Key Duties and Responsibilities

- Provide high quality community development support
- Providing support to existing local community groups so they can be partners in developing services
- Work closely with primary care teams, Oxfordshire Mental Healthcare NHS Trust, health advocates and the Community Support Workers for North and South Oxfordshire in improving access to and developing mental health services for BME communities and have input into the service redesign process

- To work in partnership with voluntary sector BME workers (MIND and Mental Health Matters) to develop means of targeting local needs and hard to reach groups in the community.
- Leadership development and capacity building through creating and delivering training and development activities.
- Providing support to develop skills, knowledge and confidence to become involved in creating local solutions.

Responsibilities applicable to all managerial posts within the Trust

- Health and Safety
- Human Resources
 - To enshrine the principles of Improving Working Lives to support staff in developing an effective work/life balance.
 - To ensure that all staff undergo an annual performance review in line with the Trust Policy and have an up to date Personal Development Plan.
 - To be responsible for own professional development and to participate in the Trust Performance Review Process.
- Governance
- Information
 - To be responsible for maintaining the confidentiality of all patient and staff records in your area.
 - To be responsible for ensuring that all staff within your department adhere to all areas of the Data Security Policy.
 - To be responsible for addressing all security and confidentiality training needs of staff on induction and annually thereafter.
- Code of Conduct
 - To enshrine the principles of the NHS Code of Conduct for Managers in undertaking all aspects of your role.

Person Specification

Skills	Essential	Desirable
Education and Qualifications	At least 2 years experience of working with and for communities either in the statutory or voluntary sector	Experience of working within primary care
	Evidence of a good general education and a demonstrable ability to learn and apply knowledge	Development and delivery of training programmes
	Underpinning knowledge of mental health or community to complete the Level 2 Certificate in Mental Health Work	
Skills/Knowledge	Ability to work with a range of people in different settings	Understanding of public health issues
	Experience of working collaboratively with a range of agencies	Language skills
	Experience or understanding of using a non-western/ Eurocentric model of community development approaches with diverse multi racial groups	
	High level understanding of the current agenda around impact of institutional racism	
	Service user engagement skills or experience	
Personal Qualities	Excellent communication and networking skills	
	Commitment to working to eradicate inequality	
	Ability to work autonomously as well as part of a team	

Appendix O

Career Development

Career Development and the Knowledge & Skills Framework

The Career and Skills Escalator

[From the CSIP/NIMHE South East Development Centre Toolkit]

1. Historically, the NHS has complex and sometimes limiting career pathways, often allowing individuals only to access specific occupations. In contrast, a 'Skills Escalator' model can be applied at all levels, across all types of jobs, roles and duties within the NHS.
2. A Skills Escalator can enable people to achieve new careers by accessing education and training through alternative rather than traditional routes. Many professionals are familiar with the culture of continuing professional development (CPD) and embark upon many forms of learning. The whole ethos of CPD is not about attending courses or gaining qualifications, but learning and developing in an open and unrestrictive manner with an ability to learn from experience in order to improve service delivery.
3. Transferring knowledge from a 'life' situation is relevant. The skill of childcare, caring for elderly or sick parents; supporting peer and others' learning provides a wealth of rich nutrients on which to feed. The need to unlearn previous practice is also fundamental. A Skills Escalator will take into account an individual's previous learning and experience whilst addressing immediate development needs.
4. The successful use of a Career Escalator:
 - Ensures effective retention of staff
 - Helps to contribute towards workforce planning, meeting the needs of the NHS now and in the future
 - Develops and utilises the skills of the existing workforce
 - Widening diversity throughout the organisation
 - Provides encouragement that employees can continually develop throughout their career
 - Through personal development all staff have the opportunity to reach their full potential

- It is a strategy for supporting the delivery of the Improving Working Lives agenda and the attainment of Investors In People standard
 - Increases the number of staff entering employment within the NHS at all levels
 - Within the community, promotes the NHS as a worthwhile career
 - Provides a comprehensive career ladder with access points at a variety of levels including straight from school or without formal qualifications
5. While it is easy to talk generally about a Skills Escalator approach, key points need to be emphasised:
- Traditional benchmarks such as of achieving standard GCSE grades are not an indication of the suitability of a persons' career in the NHS
 - To be effective full staff involvement is required. Shared approaches to problem solving need to be applied
 - Collaborative working with partner organisations is fundamental. The understanding and acceptance of their agendas and approaches is important, although sight must not be lost of our own expectations. This in turn, will help deliver the requirements of the NHS Plan
 - Schools, community groups, career services are also partners in the recruitment and retention cycle
 - Adequate resources are needed; time, skills and the commitment in making the Skills Escalator succeed are as important as funding
 - Not everyone will want to develop his or her career. A minority will not wish to enhance their skills and knowledge, and this must be respected
6. The Skills Escalator cannot be a stand-alone initiative – it must be embraced within the core of the business, embedded into the clinical governance framework and a key component of the organisational development strategy. The principles need to be applied across the whole organisation to ensure consistency and full inclusion.

Career Pathway – Community Development Worker

7. This concept provides a possible development pathway showing how the CDW is trained and developed within the role.
- Year one, the Foundation Gateway (KSF Outline) working within a team whilst completing a qualification programme (if required).
 - Year two, Secondary Gateway (KSF Outline) will consolidate learning and develop experience and competence, showing greater responsibility and ability to work with less supervision. The job designed will be based on local need and the CDW will develop higher expertise within specific activities or areas supported by local CPD. This could be supported at an academic level through a Foundation Degree. This may also lead to the CDW taking up a senior role.

Appendix P

Revised Race Equality

Lead Contact details

Region	Appointee	Contact Details
North East/Yorks. & Humberside	Selina Ullah	selina.ullah@bdct.nhs.uk Work: 01274 228370 Mobile: 07957 425451 PA: Jane French Tel: 01274 228298 Jane.French@bdct.nhs.uk
North West	Manjeet Singh	Manjeet.singh@northwest.csip.org.uk Mobile: 07834 891345 Administrator: Faizah Tel: 0161 3514921
East Midlands	Asha Day	Asha.day@eastmidlands.csip.nhs.uk Work: 01623 812942 Mobile: 07766 026679 PA: Helena Kelley Tel: 01623 812 942 Helena.Kelley@nimhe-em.nhs.uk
West Midlands	Ranjit Senghera	ranjit.senghera@csip.org.uk Work: 01527 587622 Mobile: 07780 681763 PA: Lorraine Barnes Tel: 0121 678 4850 Lorraine.barnes@csip.org.uk
Eastern	Dean Pinnock	Deanpinnock@aol.com Dean.Pinnock@nemhpt.nhs.uk Work: 01279 827455 Mobile: 07786 332239 Eastern DC Administrator: Valerie Lofthouse Tel: 01206 287593 valerie.lofthouse@nemhpt.nhs.uk

South East	Poppy Jaman	poppy.jaman@sedc.nhs.uk Work: 01256 376394 Mobile: 07795 298944 Administrator: Elaine Taylor Tel: 01256 376394 Fax: 01256 376309 elaine.taylor@sedc.nhs.uk
London	Denise Bobb	Denise.bobb@londondevelopmentcentre.org Work: 020 7307 2427 Mobile: 07815 773046
South West	Mark Patterson	mark.patterson@nimhesw.nhs.uk Work: 01278 432 002 Mobile: 07884 492741 PA: Leanne Caldwell Tel: as above Leanne.caldwell@nimhesw.nhs.uk

Appendix Q

Glossary

A4C	Agenda for Change
ASW	Approved Social Worker
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CCAG	Culturally Competence And Awareness
CD	Community Development
CDW	Community Development Worker
CHN	Community Health Networks
CMHT	Community Mental Health team
CPD	Continuing Professional Development
CSIP	Care Services Improvement Partnership
DC	Development Centre
DH	Department of Health
DRE	Delivering Race Equality
E&T	Education and Training
EIS	Early Implementer Site
ESC	(Ten) Essential Shared Capabilities
FIS	Focussed Implementation Site
GCSE	General Certificate of Secondary Education
HAZ	Health Action Zone
IPR	Individual Performance Review
K	£1,000
KSF	Knowledge and Skills Framework
LA	Local Authority

LDP	Local Delivery Plan
LIT	Local Implementation Team
LMU	Leeds Metropolitan University
LSP	Local Strategic Partnership
MH	Mental Health
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
NOS	National Occupational Standards
OP	Older People
OPMH	Older People's Mental Health
PCT	Primary Care Trust
PSA	Public Service Agreement
RECC	Race Equality and Cultural Capability
REL	Race Equality Lead
REP	Race Equality Plan
SE	South East
SHA	Strategic Health Authority
STR	Support, Time and Recovery (worker)
WDD	Workforce Development Directorate
WYWDD	West Yorkshire Workforce Development Directorate



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278271/*Community Development Workers Handbook* and contact:

John Allcock
Associate Director
National Workforce Programme (NWP) National Institute for Mental Health (England)
Care Services Improvement Partnership
Wellington House
Second Floor, South Wing
133-155 Waterloo Road
London SE1 8UG
Fax: 020 7972 4681
E-Mail: john.allcock@dh.gsi.gov.uk

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