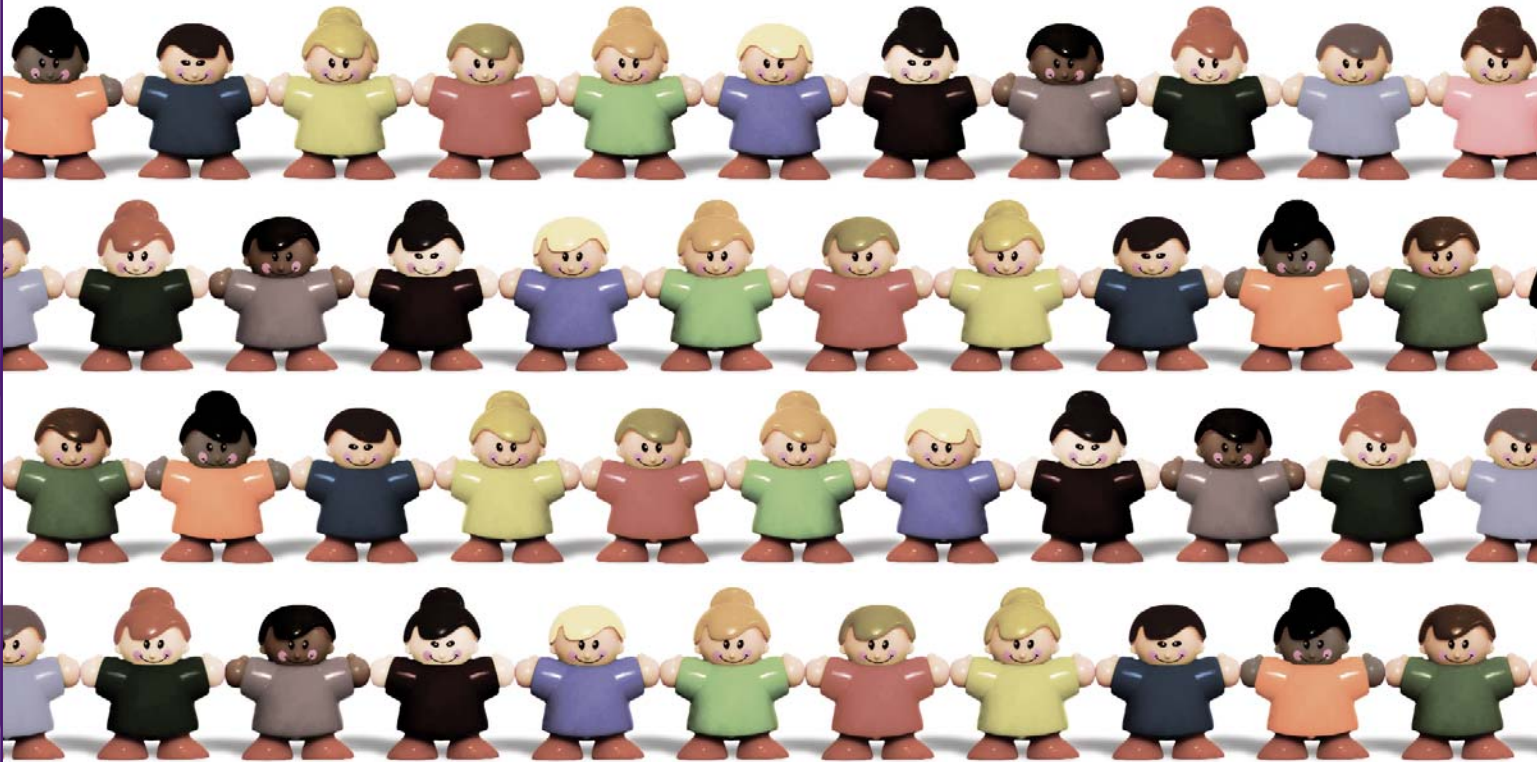


Care Services Improvement Partnership **CSIP**

National Institute for
Mental Health in England



More than just staffing numbers

A workbook for acute care workforce redesign and development



DH INFORMATION READER BOX

Policy	Estates
HR / Workforce Management	Commissioning
Planning /	IM & T
Clinical	Finance
	Social Care / Partnership Working

Document Purpose Best Practice Guidance**Gateway Reference** 10397**Title** More than Just Staffing Numbers**Author** NIMHE Acute Care and National Workforce Programmes**Publication Date** 23 Sep 2008**Target Audience** PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Medical Directors, Directors of Nursing, Directors of Adult SSs, Directors of Finance, Directors of Mental Health, Service Improvement Leads,**Circulation List** Foundation Trust CEs , Allied Health Professionals, Voluntary Organisations/NDPBs**Description** More than just staffing numbers is a positive practice workbook designed to assist local mental health services address key workforce issues in the review, planning and re-design of their adult acute mental health service. It has been issued as a companion document to Laying the Foundations for better acute mental health.**Cross Ref** Laying The Foundations for better Acute Mental Health Care (CSIP, DH, Estates 2008)
The pathway to recovery (HC 2008), New Ways of Working for Everyone (DH 2007)**Superseded Docs** n/a**Action Required** n/a**Timing** n/a**Contact Details** Mrs Yvonne Stoddart
NIMHE Acute Care Programme
Genesis 5, Innovation Way
Heslington, York
YO10 5DQ
01904 717260
www.virtualward.org.uk**For Recipient's Use**

Contents

Acknowledgements	2
Foreword	3
Executive Summary	4
1 Introduction	5
2 The Acute Care Pathway	11
3 Addressing Workforce Change	14
4 Experiences of Acute Workforce Redesign	20
5 Learning the Lessons from the Experiences of Acute Workforce Redesign	43
6 Conclusion	46
Glossary	47
Summary of examples and contact details	48
References	49
Appendix 1 Healthcare Commission Assessment Framework Summary	55
Appendix 2 Tools, Resources and Sources of Information	56



Acknowledgements

This guidance was developed as a collaborative project between the National Institute for Mental Health in England (NIMHE) Acute care and National Workforce programmes.

Authors

Tony Ryan, *Independent Consultant, Tony Ryan Associates*

Paul Rooney, *NIMHE Joint Lead, National Acute Care Programme*

Acute Workforce Subgroup

Ian Baguley, Roslyn Hope, Barry Foley, Alan Howard, Hugh Middleton, Sara Munro, Malcolm Rae, Mike Reid, Yvonne Stoddart, Nicola Vick

Contributors

Lisa Agell, Jon Allen, Ros Alstead, Mandy Bailey, Neil Brimblecombe, Albert Caracciolo, Isabel Clarke, David Curtis, Ripu Deo, Steve Eley, Wendy Fisher, Gillian Green, Paul Greenwood, John Hanna, Phil Hodes, Judith Hurst, Allan Jolly, John Keaveny, Alison Kendall, Keith Linley, John McGowan, Paddy McKee, John Marshall, Gary O'Hare, Janice O'Hare, Pam Travers, Geraldine Strathdee, Mary Shinner, Paul Sturgeon, Seamus Watson, Chris Wager, Jonathan West and Deborah Wildgoose.

Consultation

The following groups were also consulted:

National Acute Mental Health Project Board

National Acute Mental Health Steering Group

NIMHE Regional Acute Leads



Foreword

More than Just Staffing Numbers is a welcome and timely addition to the range of acute care service improvement tools and initiatives that have been produced in recent years. It should prove very helpful to Trusts in addressing the key workforce issues within their local action plans arising from the recent Healthcare Commission review of acute inpatient services.

Acute care mental health services have made considerable progress since the launch of the National Service Framework and the subsequent Policy Implementation Guidance on crisis resolution home treatment and acute inpatient services but there is still much to be done.

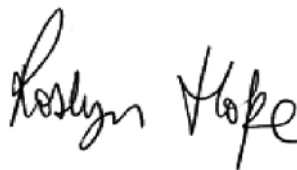
While there is no quick fix solution, there are now many more local services providing effective and individualised acute care and better choices in more therapeutic environments. Investment in new services and facilities has been a critical factor in achieving this, but therapeutic care is dependent on having the right staff with the right attitudes and skills in the right place. The development of the acute care workforce is core to achieving better service delivery and the effective alignment of service components within the acute care pathway.

This positive practice workbook will help develop knowledge and understanding of the key dimensions of the integrated acute care pathway for workforce development; of approaches to workforce redesign and a raised awareness of innovative practice from the practical examples.

This workbook is the result of a collaborative project between NIMHE's Acute Care and Workforce programmes. It has been produced because it remains important to develop better career opportunities for all acute care staff in order to assist the recruitment, retention and deployment of key skills where they are most needed by service users when they are acutely unwell. The practical examples of workforce change and service improvement in the workbook are strong evidence of what can be achieved and clearly demonstrate the enthusiasm and commitment of staff from across the disciplines.



Dr Hugh Griffiths
*Deputy National Clinical Director
for Mental Health*



Roslyn Hope
*Director NIMHE National
Workforce Programme*



Executive Summary

This positive practice workbook provides a framework for acute care workforce redesign and development by defining the whole system and integrated care pathway for service improvement. It also provides an overview of how the workforce can be developed by using approaches such as the Creating Capable Teams Approach (CCTA) and related methodologies to achieve practical and sustainable change.

The experience of 15 Trusts who have undertaken workforce redesign in acute care services provides a practical insight into the ways in which services have tackled service and staffing development processes. The lessons gleaned from their experiences provide a very real and helpful insight into developing the acute care workforce in an innovative, effective and achievable manner. It is hoped that these examples inspire other to learn from their experiences.

Key success factors identified as enabling acute care workforce redesign:

- Executive/ Board level interest and support to prioritise the need for acute care service improvement.
- An emphasis on service user and carer experience and their active involvement in defining objectives.
- Developing a 'can do' culture and a structure which supports change and continuous improvement.
- Affirming and acknowledging the skills of existing staff (included unused skills and life skills) and identifying skill gaps.
- Active leadership and collaboration by senior clinical and management staff in and across the acute care services is vital.

- Having a clear focus on the vision, purpose and functions of the proposed service and associated workforce change and getting sign up to the project by all those that it would affect. A "top down / bottom up" approach was evident in many of these services.
- Focusing on key events and interfaces and being very specific about the who, what where and when of proposed arrangements and associated new ways of working.
- Paying specific attention to the interface issues between components of the acute care pathway in order to ensure care pathway consistency and coherence. A whole system approach can identify key points in the pathway that need focused attention and provide opportunities for innovative workforce development across pathway services.
- An open approach based on evidence, baseline data, audit and feedback.
- The ability of professional groups or individual service components to see the bigger picture rather than their own sphere of practice and consequently avoiding being "precious" or territorial.
- Use of workforce planning methodologies and tools such as CCTA.
- A pragmatic approach – learning by doing. There needs to be a balance between involving people and getting the job done. Small changes can make a big difference.
- Clear management of the workforce redesign process with a project group structure, dedicated resources and timescales. These need to be reviewed regularly for effectiveness and to maintain momentum.
- An openness to partnership opportunities and learning from other organisations.
- An empowered Acute Care Forum can make a valuable contribution to enhancing involvement, communication and the sustainability of workforce innovation.



1 Introduction

Aims of the workbook

The aims of this positive practice workbook are to:

- Provide an overview of the role and function of the component services of the acute care pathway with a specific focus on acute inpatient provision.
- Provide practical support and encouragement to acute care workforce redesign and planning.
- Learn from positive practice examples how New Ways of Working are being introduced to develop and improve acute care service delivery.
- Act as a signpost for evolving learning with details of contacts willing to share their experiences.

Who should use this document

This workbook is intended to support staff, managers, commissioners, service users and carers involved in acute care service planning and development in working together to determine, provide and develop the skilled workforce required by users and carers when using acute mental health services.

It is also intended to inform and support services in how they how they implement New Ways of Working and the use of support tools such as the Creating Capable Teams Approach when considering acute care services.

Scope of document

Throughout the workbook, "acute care services" refers to the whole system of acute care provision for those who are acutely unwell – a system that needs to include crisis resolution home treatment and inpatient care options as integrated components of the same care pathway. It pays specific attention to inpatient services as they undergo significant change.

A question that has frequently been asked by people working and managing acute in-patient services has been: "How many staff do we need to run the ward?" If only it were that simple – it's more than just staffing numbers. Things have moved on from how to staff the ward towards how best to staff the overall service, paying particular attention to key interfaces and ensuring a balanced distribution of staff and skills across the care pathway. There is a need to craft local solutions to local situations to ensure the development of a workforce that is reflective of the diversity of the population served. Each area will have its distinct service configuration, own population needs and its own range of staffing skills and challenges.

Therefore, this workbook has been designed to provide practical and logical support to local service development rather than prescribe a 'one size fits all' approach.



Context

The starting point for workforce planning and development in acute mental health services is to address the key questions (numbers, skills, responsibilities, relationships, support) in the context of being clear about what users and carers want and need both from the service overall and from the component parts of the service that make up the acute care pathway.

Historically inpatient services have been the mainstay of acute care provision. They have attracted the major part of mental health resources and are an area of mental health that has long and well established ways of working. Acute inpatient service planning and development has tended to be developed on the basis of historical bed numbers, service use and funding patterns rather than what would best suit the needs of service users and carers (Munro & Baker, 2007).

Since the introduction of the National Service Framework for Mental Health (NSF) (DH, 1999) there has been a shift in emphasis towards designing integrated services that provide a wider range of choices to better fit the needs of users and carers and which are recovery oriented (CSIP, 2006). Key to the modernisation of acute care services has been the wide scale introduction of Crisis Resolution Home Treatment (CRHT) services which has presented both opportunities (reducing inappropriate admissions and overcrowded wards, facilitating early discharge) and threats (potential loss of staff and skills from inpatient wards) to the improvement of the existing acute inpatient services.

Since the launch of the NSF there have been a number of policy and practice initiatives which should guide how the acute care workforce is developed. Key amongst these are:

- Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision (DH, 2002) which established the need for an integrated care pathway context for the development of inpatient services and the creation of acute care forums (ACFs) within trusts as the major vehicles for overseeing local development of acute care services.
- Mental Health Policy Implementation Guide (DH, 2001) which sets out the service specification for CRHT services including suggested staffing levels and skill mix. This guidance has since been updated by the Guidance Statement on Fidelity and Best Practice for Crisis Resolution Teams (DH/CSIP, 2006).
- The National Audit Office value for money report Helping People Through Mental Health Crisis: The role of Crisis Resolution and Home Treatment Services (NAO, 2007) which encourages closer joint working between CRHT and acute inpatient services and the need to better ensure dedicated input from key health and social care professionals, particularly consultant psychiatrists.
- The Healthcare Commission's service review of acute inpatient services. In 2007, the Healthcare Commission undertook an acute inpatient service review of all statutory mental health providers which assessed whether admissions to acute inpatient mental health services were appropriate, purposeful; therapeutic and safe.



The Healthcare Commission's assessment framework (see Appendix 1) provided a basis for evaluating and benchmarking local performance against four criteria:

- There is an effective care pathway that ensures admission to hospital is appropriate and that discharge from hospital is timely
- Inpatient services provide individualised whole person care that promotes recovery and inclusion
- Service users and carers are involved in care planning, in how the ward is run and in operational and strategic planning, evaluation and development
- The ward has systems, processes and facilities in place to ensure the safety of service users, staff and visitors.

In July 2008, the Healthcare Commission published the results of the review in their national report *The Pathway to Recovery: A review of NHS Acute Inpatient mental health services* (HC, 2008). The National Acute Mental Health Project Board and the National Institute for Mental Health in England (NIMHE) acute care programme have collaborated closely with the Healthcare Commission on the review and will continue to work with them and local providers to focus on addressing key service improvement priorities arising from the results of the assessments.

The Healthcare Commission's acute inpatient service review is the most comprehensive benchmarking of NHS acute mental health inpatient services ever undertaken and offers a robust mechanism for evaluating and monitoring current local performance, informing future local acute commissioning and service development priorities and sustaining service improvement to achieve an effective integrated acute care services.

The Healthcare Commission advocates an integrated approach to acute care service development that ensures improvement to acute care services is coordinated with the development and delivery of other policy objectives including: delivering race equality (DRE), improving access to psychological therapies (IAPT), refocusing the Care Programme Approach (CPA), managing people with dual diagnosis problems and the implementation of amended mental health legislation.

All statutory mental health providers are expected to develop local service improvement plans, arising from the results of the assessment, which have been negotiated and agreed with local commissioners. Evidence of locally agreed plans has been included in the 2007/08 Autumn assessment. Workforce development planning issues across the acute care pathway are likely to be a critical element of these plans.

In addition to responding to the demands of current mental health policy a number of imminent and future challenges face those developing the acute care workforce:

- **Legislation** The Mental Health Act 2007 becomes operational in November 2008. There is also the ongoing requirement to implement the Mental Capacity Act (2005).
- **Finance** The introduction of Payment by Results and the roll out of Foundation Trusts will have a significant financial impact on service providers and their workforce.
- **Clinical practice** The review of the Care Programme Approach (CPA) Refocusing the Care Programme Approach: policy and positive practice guidance (DH, 2008) is being rolled out for implementation in October 2008.



Challenges facing acute care services

Meeting need	Workforce demands
<ul style="list-style-type: none"> • Changing demand/demographics • Increasing service user acuity and complexity • Managing service users with dual diagnosis problems • Meeting the physical health care needs of service users • Addressing inequalities encompassing race, gender, disability, sexual orientation, age, religion or belief. • Meeting the needs of carers • Ensuring therapeutic service user engagement and delivery of personalised care • Therapeutic management of violence and aggression • Prevention of self harm and injury • Providing access to short term psychological therapies • Developing recovery focused practice • Protecting and promoting social inclusion for service users • Refocused CPA implementation • Measuring and delivering service user focused outcomes 	<ul style="list-style-type: none"> • Responding effectively to the Healthcare Commission review findings • Integrating acute inpatient wards with CRHT services • potential loss of inpatient staff to different community teams • Developing clinical and managerial leadership for the overall pathway and its component services • Implementing New Ways of Working including integrated new roles and changing clinical practice across the acute pathway • Implementing values based learning and practice, based on the Ten Essential Shared Capabilities Framework • Addressing gaps in training and personal development at all levels • Developing multidisciplinary approaches to systematic risk assessment and management • Releasing staff time to develop team working and development (e.g. Creating Capable Teams) • Clinical supervision and support systems • Meeting regulatory and statutory requirements • Meeting equality legislation requirements regarding race, disability, gender, sexual orientation, age, religion or belief • Mental Capacity Act (2005) • Mental Health Act 2007 • Organisational changes (e.g. mergers, Foundation Trusts)

Workforce planning tools and resources

This policy shift has also highlighted the importance of developing practitioners and a workforce capable of delivering the services and outcomes required. To address this, a range of tools and resources have been developed to assist the planning and development of an NSF appropriate mental health service workforce:

- *New Ways of Working (NWW)*, which is at the heart of workforce development and covers all professions and services in mental health (DH, 2005, 2007).
- *The Creating Capable Teams Approach* (DH, 2007).
- *The Ten Essential Shared Capabilities framework* (DH, 2004).
- *From Values to Action: The Chief Nursing Officers review of mental health nursing* (DH,



2006), which recommends the need to review career pathways for nurses in acute care, improve integration of acute inpatient care with acute community services and develop recovery focused support to users.

- *Acute Inpatient Mental Health Care: Education, Training and Continuing Professional Development for All* (NIMHE/SMCH 2004)
- New roles arising from the implementation of the refocused CPA 2008 and the 2007 Mental Health Act.

Section 3 'Addressing Workforce Change' considers these workforce initiatives in more detail. For a more extensive range of tools and resources relevant to developing the acute care workforce see Appendix 2.

Acute care service redesign – 'Laying the Foundations'

In order to encourage acute care planning and service redesign within a whole systems context, NIMHE's Acute programme has recently developed a range of related tools to assist both commissioners and providers of acute mental health services. These include:

- *Onwards and Upwards: Sustaining service improvement in acute care* (CSIP, 2007).
- *A Positive Outlook: A good practice toolkit to improve discharge from inpatient mental health care* (CSIP, 2007).
- *Informed Gender Practice – Acute Mental health care that works for women* (CSIP/RCN, 2008).
- The Virtual Ward website at <http://www.virtualward.org.uk>

In any significant acute care redesign and development exercise, critical decisions need to be made as to how the service is to be staffed and accommodated. These decisions, which will have major long term consequences for future service flexibility, need to be made in the context of absolute clarity regarding service functions, aims and outcomes and the care pathway needed to deliver them.

NIMHE's Acute Care programme recently collaborated with DH Estates and Facilities and the NHS Confederation to jointly publish the 'Laying the Foundations' workbook (CSIP/DH 2008) which sets the context for acute care service planning and any necessary related capital development. This service redesign workbook should be used as a companion document to 'More Than Just Staffing Numbers', with both workbooks using the same initial 3 steps to determine the appropriate service model and care pathway that should underpin local service and workforce planning.

Both documents have been produced to help services respond to planned service changes and to maximise the opportunities provided by the Healthcare Commission review. 'Laying The Foundations' uses a five step process to acute care service redesign. The first three steps are common to both acute care service and workforce planning. They focus on service redesign and planning decisions and the last two on potential associated capital investment decisions.

Completion of the first three steps of the Laying the Foundations' process will help ensure that your workforce planning is also fully grounded in a clear understanding of the key service values and principles, the desired care pathway and what outcomes you are trying to achieve. It is crucial that your workforce and service redesign and reform initiatives are fully aligned.

The five step process to acute care service redesign is summarised in the following table.



Laying The Foundations –The Five Stepped Approach

Asking the right questions	Gathering Information	What it means for you
Step One What are your aims and desired outcomes?	<ul style="list-style-type: none"> • What are the national policy drivers, legal requirements and evidence for acute mental health care? • What are your service aims and desired outcomes? 	<ul style="list-style-type: none"> • How well are you doing against these and what challenges remain?
Step Two What does the model pathway look like?	<ul style="list-style-type: none"> • What are the local whole system influences on demand? • What capacity will be needed to flexibly meet the demand? • In what ways, and with what effects, could this capacity be apportioned to the service components? 	<ul style="list-style-type: none"> • What does an ideal integrated care pathway look like for your area? • What relationships do you need to enable effective functioning between service components?
Step Three How well does your current service model fit the desired care pathway?	<ul style="list-style-type: none"> • What is the gap between the ideal model and your current care pathway in terms of numbers of places, apportionment and efficiency? • What are the options for improving the efficiency of the care pathway and service users' experience of it? 	<ul style="list-style-type: none"> • Are new facilities necessary to enable quality improvement in the whole acute care pathway?
Step Four How can you make the best use of your workforce?	<ul style="list-style-type: none"> • How can you improve patient, staff and carer experience of acute inpatient services and ensure any inequalities are met? • How can the links between inpatient services and other components of acute care work best for service users? 	<ul style="list-style-type: none"> • What are the potential capital investment options to facilitate achievement of desired outcomes and an optimum care pathway? • What are the implications of the options for different service user journeys and from different stakeholder perspectives?
Step Five How do you develop your workforce plan?	<ul style="list-style-type: none"> • How does all this plug into the formal planning processes for capital investment? Progressing to the Health Building Note 	<ul style="list-style-type: none"> • What steps will you take to formalise your capital investment?

Included in Step One: Task 1 of “Laying The Foundations” is a template that includes specific room for including and developing staffing outcomes. This can be downloaded from www.nimhe.csip.org.uk/silo/files/ltf-template.doc



2 The Acute Care Pathway

Definition of the acute care pathway

What is meant by the “acute care pathway” or “acute care service”?

Acute mental health services serve those people experiencing, at risk of or recovering from a mental health crisis, and comprise a number of key component service elements. The term ‘acute care pathway’ used throughout the document refers to the journey a service user makes from initial referral to discharge from acute services. An ‘integrated pathway’ refers to the interlinked services and agencies working together to support service user and carer needs and achieve the desired outcomes. An effective pathway is one where all those involved in providing the service share aims, priorities and values as well as operational policies. The relationships between the component parts are as important as the properties of the parts themselves. There need to be clear arrangements in place for the cohesive overall management of a locality’s acute care services and its workforce.

What are the core component services of the acute pathway?

Crisis resolution/ home treatment team (CRHT): a mobile multidisciplinary team operating 24 hours, 7 days a week, which provides treatment at home for those acutely unwell but not requiring admission, gate-keeps (assesses the appropriateness) of inpatient admissions and facilitates early supported discharges. It is recommended in the policy implementation guidance (DH, 2001, 2006) that a standard CRHT of 14 staff covers a population of 150,000.

While home treatment constitutes the major part of a CRHT’s workload, the team should also provide intensive support to help people be discharged from inpatient care earlier than would otherwise have been possible.

Respite/Crisis house provision: in some areas CRHT can also access and support people in crisis beds for those who cannot be treated at home but do not need to be admitted to hospital. This provision is usually made in ordinary supported housing in partnership with local voluntary or social care organisations.

Inpatient beds: are an essential part of an integrated acute care pathway, intended to ‘provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness.’ Admissions are considered where this would play a necessary and purposeful part in a person’s progress to recovery from the acute stage of their illness.

Acute day treatment services: provide an alternative to admission for people who are acutely unwell and are a means of facilitating early discharge and preventing readmission. Acute day treatment services may be provided as an integral element of an acute hospital unit or as a stand alone facility.

Psychiatric intensive care unit (PICU): part of the overall acute service which provides a more intensive level of inpatient support and intervention for those people exhibiting high levels of agitation or disturbance, as well as for those who maybe particularly vulnerable. PICUs usually serve a wider catchment area population than a CRHT or admission ward. They can be sited as a stand alone unit adjacent to other mental health inpatient facilities or as a ward within a larger unit. (DH, 2002)



Place of safety provision: a small suite of rooms for the emergency psychiatric assessment of those detained by the police under s.136 of the Mental Health Act. These have often traditionally been located in police stations, but it is now considered far more appropriate to site them within mainstream healthcare adjacent to or as part of an acute unit (revised MHA Code of Practice DH, 2008).

Step-down and supported housing accommodation: some services find it helpful to develop partnership arrangements with voluntary and independent sector providers to ensure patients discharge from acute care is not inappropriately delayed.

Depending on the local context, other services will link, directly or indirectly, to the acute care pathway services such as:

- Accident and Emergency/liaison services.
- Acute medical wards.
- Primary care services.
- Early intervention services.
- Drug and alcohol services.
- Assertive outreach services.
- Police (particularly in relation to Section 136 of the 1983 Mental Health Act).

Developing Your Acute Care Pathway(s)

Clarity about your acute care pathway and how you want component services and staff groups to collaborate is essential to effective workforce planning. An integrated care pathway is required to coordinate delivery of the most appropriate level of care at different stages of the care plan. There should be a clear care pathway for the acute care service overall and for each of the component services (inpatient, PICU, CRHT, place of safety...).

How services are configured into a locality acute care pathway differs across the country for a variety of reasons. It will depend on a wide range of factors, including: local service structures (the individual services and their management and governance), resources (the staff and facilities available), geography (urban, semi-urban, rural, coastal and mixed conurbations will operate differently) and the needs of the local population.

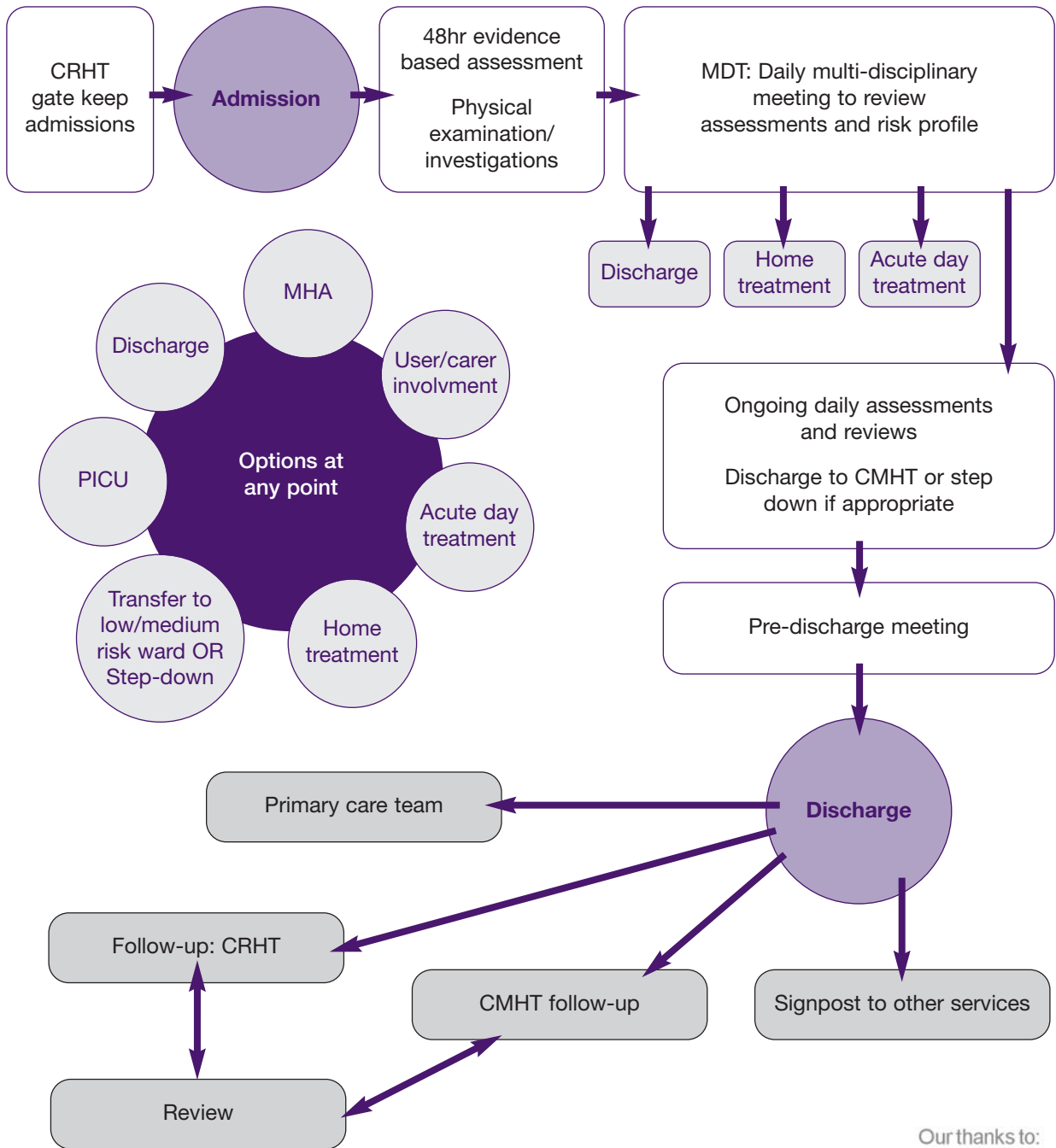
All acute care pathway services should adhere to a number of shared principles and policies to ensure integrated service delivery in practice:

- Single management and unambiguous lines of responsibility.
- Consistent gate-keeping procedures.
- Consistent care planning arrangements across the pathway.
- Single assessment at point of entry including risk assessment which is consistently revised.
- Discharge planning from the start.
- Clear purpose for each admission to the pathway.
- Effective and consistent communication mechanisms between clinicians, teams, and agencies.

An illustration, from Cumbria Partnership NHS Trust, of how the core component parts and key relationships between functions of the acute inpatient care pathway are organised is shown in the diagram opposite. More care pathway information and good practice examples of each of the component services can be accessed via the Virtual Ward website at <http://www.virtualward.org.uk>



The Acute Care Inpatient Pathway



Our thanks to:

Cumbria Partnership **NHS**
NHS Trust

3 Addressing Workforce Change

New Ways of Working (NWW)

New Ways of Working (NWW) is about developing a more flexible and skilled mental health workforce by meeting the needs of service users and carers in a cost effective manner which is also fulfilling to staff. All national professional bodies have signed up to NWW and to what it means for their members. The multidisciplinary team is at the heart of NWW; there are specific issues for all staff groups, but the direction of travel is the same: encouraging an approach where responsibility for meeting the needs of service users is undertaken by the most appropriate individual professional or professionals within the team. With the implementation of the new Mental Health Act from November 2008, the Responsible Medical Officer (RMO) responsibility for a detained patient will be replaced by that of the 'Responsible Clinician' who will need to be an Approved Clinician. This role will be able to be undertaken by nurses, social workers, psychologists or occupational therapists, providing that they have the required competences.

Where a person is an informal patient, they are still likely to have a psychiatrist with overall responsibility because of their complex needs. There is an expectation, however, with the revised CPA, that the care co-ordinator will maintain the overview and co-ordinating function when people have an acute episode. Increasingly, we are seeing nurse managed units and other professionals, such as occupational therapists becoming ward managers. NWW is concerned with ensuring that the people with the greatest skills and experience work closest to those with the most complex needs and that their skills are also used to supervise and support others who are developing their expertise.

Well functioning multidisciplinary team working with people on CPA is probably the most obvious area where this operates, as it involves individuals from across teams and professions coming

together to collaborate as a team for an individual service user. This is particularly pertinent to the whole system delivery of acute care where co-ordination and collaboration across the care pathway services is critical. It may be particularly challenging for some acute care inpatient services, because traditional ways of working can be the most difficult to change and improve upon, even in the face of evidence of the need to change (Middleton et al, 2007) and because many inpatient services have experienced difficulty in recruiting and retaining staff skills and experience in competition with new community services. In reviewing the workforce issues on the care pathway, it is essential to clarify local assumptions about clinical and care pathway responsibility.

NWW also encourages re-examining traditional roles and practice to enable more effective use of existing knowledge and skills (some of which may be misdirected, under utilised or unused) and to improve job satisfaction and career development for staff. This is an ideal opportunity for services to address issues relating to equality and diversity within their workforce to ensure that all staff groups have equal access to opportunities. Specific initiatives have been undertaken to promote NWW with the key staff groups and their professional bodies including:

- Allied health professionals.
- Mental health nurses.
- Occupational therapists.
- Pharmacists.
- Psychiatrists.
- Psychologists.
- Social workers.
- New roles (e.g. support, time and recovery workers) and non professionally qualified staff.

New Ways of Working for Everyone. A best practice implementation guide (CSIP, 2007) was



published to assist trusts and other employers in thinking about implementing NWW for all disciplines. It contains an action planning framework to strategically consider how all the elements of NWW could be linked into the integrated service and business planning process of the organisation. Lessons from recent learning sets on implementing NWW, involving over 35 Trusts nationally are also available.

Further details on these initiatives can be found via the NWW website at <http://www.newwaysofworking.org.uk>

The Ten Essential Shared Capabilities

The Ten Essential Shared Capabilities (ESC), developed in consultation with service users, carers and practitioners, define the essential capabilities required to underpin workforce and service development. These have evaluated learning materials to support their implementation available from <http://visit.lincoln.ac.uk/C6/C12/CCAWI/default.aspx>

The Ten Essential Shared Capabilities for Mental Health Practice

Working in Partnership Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

Respecting Diversity Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

Practising Ethically Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

Challenging Inequality Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.

Promoting Recovery Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

Identifying People's Needs and Strengths Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users their families, carers and friends.

Providing Service User Centred Care Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

Making a Difference Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

Promoting Safety and Positive Risk Taking Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.

Personal Development and Learning Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.



The Creating Capable Teams Approach

The Creating Capable Teams Approach (CCTA) was developed and launched in 2007 to assist services and teams to implement new ways of working systematically. CCTA is a tool with a clear workforce focus designed to help teams and individuals examine their approach to meeting the needs of service users and carers and better define their key functions. It can

assist in supporting changes in practice, processes and team working. While there may be a degree of overlap, those involved in acute care planning and development may find the CCTA team development process very helpful in determining how the workforce needs to develop in the context of having first determined the service aims, outcomes and integrated care pathway(s) in steps 1-3 of the Laying the Foundations acute service redesign process outlined on page 10.

The CCTA Team development and decision making processes

STEP ONE: PREPARATION AND OWNERSHIP

Meetings with all involved and obtain organisational sign up



Team undertakes relevant preparation and sign off by Team leader

STEP TWO: TEAM FUNCTION

Explore national and local context and identify the benefits of NWW and CCTA



Understand who is in the team and the team's core values and function



Identify existing skills, experience and qualifications

STEP THREE: SERVICE USER AND CARER NEEDS

Examine the implications of the local demographic data



Identify and prioritise service user and carer needs



Identify who meets needs now and who could in future



Identify existing capabilities within the team and explore how individuals could work differently

STEP FOUR: CREATING A NEEDS LED WORKFORCE

Identify the team



Categorise changes into: New Roles, New Ways of Working, Learning and Development and other



Prioritise changes using a traffic light coding and produce action plans

STEP FIVE: IMPLEMENTATION AND REVIEW

Finalise Team Profile and Workforce Plan (TPWP)



Present key themes and changes to the Senior Management Team and agree implementation



Integrate TPWP into organisation's workforce planning and Learning and Development processes



The CCTA requires experienced facilitation and the support of an identified senior sponsor, team leader and the Senior Management Team (SMT). Its aims are to:

- Support the integration of NWW and new roles into the structures and practices of a multidisciplinary team /integrated service, within existing resources.
- Support teams to review their services based on the skills and capabilities required to meet service user and carer needs and enable them to utilise the opportunities and flexibilities that NWW and new roles offer.

A strength of the CCTA is the involvement of service user and carer participation throughout the process to facilitate a clearer understanding of their needs of the service(s) involved, as expressed by them. The initial stages of the CCTA team development and decision making process can be useful in determining how best staff skills and experience need to be distributed across the care pathway to optimise the effectiveness of service delivery.

CCTA will usefully support service redesign and organisational development. It should be undertaken as part of a wider whole systems approach to developing the acute care service and workforce – particularly at times of major change (e.g. as described in ‘Laying The Foundations’). Whilst implementing CCTA will vary from service to service depending on local circumstances, the whole process should take no longer than six months to complete. At the end of the process a Team Profile and Workforce Plan (TPWP) is produced and used as the basis of the implementation and review processes. Stage 5 of the CCTA process requires all members of the team to meet to review its implementation, probably on a quarterly basis. A staged approach towards CCTA can be useful, particularly if the resources available are less than those necessary to fully implement CCTA across the whole acute care pathway.

For further information about the CCTA go to: <http://www.newwaysofworking.org.uk/ccta.aspx>

Three trusts within CSIP North West agreed to become early implementer sites that would inform the national roll-out of CCTA, and the work of the NIMHE Acute Care Programme. Three teams from these sites completed the CCTA for adult acute care projects (2 acute wards, 1 PICU) and their Team profile and workforce plans can be found on the NWW website at <http://www.newwaysofworking.org.uk> Since then a further 3 acute teams have completed CCTA nationally.

Taking a whole system approach to the development of the acute care workforce

Whilst associated NWW approaches can be useful in providing a clear focus in clarifying workforce roles and responsibilities for component acute care services e.g. acute wards, CRHT, PICU, this should not take place in isolation as each of these services are part of the interlinked acute care pathway described in section 2 above. If development occurs in isolation it may reduce the opportunities for exploring NWW within an integrated whole system. This can be avoided by having a clearly agreed overall acute care pathway that all local services are signed up to and by sharing development responsibility across the system. Use of the five step service redesign process in the table on page 10 to link in workforce planning to any service redesign initiative will help ensure consistency.

The Healthcare Commission review re-emphasises the key role the local Acute Care Forum plays in effective acute care service improvement. It is essential to have an empowered Acute Care Forum that relates to all of the acute care services involved and not just the inpatient services.



Ensuring quality: Tackling inequalities

To help ensure that the quality mental health services provided is focused on meeting individualised needs, an appropriately trained and committed workforce is essential. From the outset, workforce development needs to address any adverse impact due to potential inequalities both within the workforce and in outcomes for individual service users and carers. All NHS organisations have clear legal duties under race, gender and disability legislation. In order to meet these requirements, an equality impact assessment should be carried out at every stage of workforce development to ensure that tackling any inequality issues are properly addressed. The Department of Health's Single Equality Scheme 2007-2010 (DH, 2007) set out how NHS bodies needed to meet current equality legislation duties (covering race, disability and gender) and also provided a commitment to tackle any inequalities regarding age, religion or belief and sexual orientation. It is likely that the impending Single Equality Duty will be extended to include all diverse groups.

A workforce review provides a great opportunity to assess and improve equality and diversity issues. It would be useful to involve the Acute Care Forum and the organizations lead in this area to assist with the process. Careful consideration should be given to the recruitment process to ensure that the workforce reflects the population it serves and ensure that those involved in recruitment and training have a good understanding of issues relating to potential inequalities regarding race, disability, gender, sexual orientation, age, religion or belief.

This document discusses the development of a more flexible and skilled mental health workforce to meet the needs of service users. Flexibility in working arrangements and in the way services are provided may allow for a more inclusive workforce and a better response to individuals needs. For example it can bring into the team skills that may have been underexploited otherwise. There are many benefits from having a diverse staff group that is reflective of the population it serves. The staff group will hold collectively a wealth of knowledge about the local community and specific needs.





4 Experiences of Acute Workforce Redesign

Below are 15 examples of actual workforce redesign approaches undertaken by acute care services. Taken together these descriptions are testimony to the efforts, successes, enthusiasm and experiences of those involved and provide valuable insights into how they went about the process.

The examples have been grouped into the following broad themes:

- Integrated models of care and care pathway redesign (examples 1 – 7)
- New Ways of Working and new roles (examples 8 – 15)

Examples of integrated models of care and care pathway based workforce redesign

Example 1: Using audit and evidence to drive acute care workforce redesign **Trust: Oxleas NHS FoundationTrust**

Workforce development issue(s) addressed:

- The inpatient wards were very busy, had high occupancy rates, patients were sleeping out on other wards and care plans were not always being followed as well as was required.

Approach adopted to workforce redesign:

- Oxleas Trust has created an internal culture of “all for one and one for all – life is too

short to waste time arguing”. The Trust has a philosophy of constantly trying to improve things and where everyone owns issues of managing the service – not just the senior managers. This team spirit has developed through having a clear user focused vision, building a critical mass of dedicated managers and practitioners and constantly reinforcing the “can do” messages. This has taken a long time to create.

- The workforce redesign process began by looking at the service to identify key problems using design-for-purpose audit tools which act as benchmarks against which to measure change.
- The main methods used to support the redesign were the embedded structures and processes that are within the Trust’s systems for reflective practice, management and development.
- Supplementing this is a culture of audit which now heavily permeates all disciplines of the Trust. The idea is to find the best practice standards, assess how we measure up against them through brief audit tools, provide a safe supportive environment to feed the data back to practitioners for reflection and then support them to use this information in order to intelligently own and drive improvement and development processes.

What worked well?

- The audit processes have driven a lot of the change. Everyone is encouraged to do audits and there are staff and effective data management systems to support this.



- Audits of handovers led to a template being designed covering the information that was essential to the acute ward team handover. This is now projected onto a screen for primary nurses and other staff and integrated with the electronic care record to enhance communication at these key parts of the day.
- Having a well functioning ACF with a clinician champion has provided a focus for key development discussion and decisions to take place.
- “The standards from the Royal College of Psychiatrists’ Accreditation for Acute Inpatient Mental Health Services scheme (AIMS) were incorporated into local ACFs as part of the local action plan. Nominated wards quickly took ownership and the change process was ‘bottom up’ leading to successful accreditation.
- A process of acknowledging users as experts through involvement in training and the use of video diaries as training aids has also been developed and made available through the Trust intranet.

What did not work so well?

- Initially the ACF did not function well, but with the appointment of an enthusiastic and committed lead consultant, it began to take off. It has required a sustained effort to get this working well, but has since reaped great rewards.
- The use of audit in 2000 was rare and it did not support service and practice development. Again this took time to become engrained in the culture of all disciplines.

Key benefits/outcomes:

- A number of areas were identified for development which improved practice and

changed roles within the workforce including nurse handovers, use of junior doctors, delayed discharges, physical healthcare, rapid tranquilisation, implementation of NICE guidelines, diet and activity for users, carers support and utilising user expertise.

- Qualified and unqualified nursing and social care staff were trained to take bloods.
- Senior nurses have been trained as Physical Healthcare Champions to deliver healthy lifestyle and smoking cessation training sessions on the wards.
- Interested nurses and occupational therapists are trained in safe use of gym equipment to educate about healthy lifestyles and tackle the sedentary lifestyle that can become part of life on a ward. In every Trust inpatient unit, a gym has opened with user input into choosing the best equipment. Each day starts using yoga principles of stretch and movement.
- Psychologists and nurses run hearing voices and recovery groups on each unit.
- The Trust intranet was redesigned to provide accessible user and carer information.
- Pharmacists have set up a medicines information helpline and training on administration of medicines competencies and now provide increased sessions on wards.
- A caseload zoning system identifies delayed discharges whereby primary nurses have an enhanced role in escalating the case as a priority for the bed manager and the ward review team.
- Ward managers have been trained in carer support and deliver carer groups in the evenings to people who support users on the wards. Family inclusive practice is now being rolled out to all members of the MDTs on the wards.



- In some parts of the Trust the model of a single acute care lead consultant to a ward has been introduced and is being evaluated.

Lessons learnt:

- The starting place for any constructive change process is in developing a culture which is supportive of this, helps staff and genuinely sees the needs of users and carers as the priority.
- It took five years to set up the structures whereby all services and professional groups had a place to go in relation to their part in developing the services. We no longer need to set up new structures as all management, practice and development work takes place in clear structures.
- Relentless effort is required to keep everything going once these structures and processes have been put in place. It requires a critical mass of committed senior leaders to encourage and enable staff, and constant effort to avoid complacency.
- Creating a culture where professional groups are not precious about their role and there is joint professional / managerial ownership of the need for change has been gradual. However, it has been essential to achieving the changes and in developing a culture of all being in this together.
- It is necessary to constantly question if you have the right vision, structures and processes to improve the service.
- It is vital that the most senior clinical staff (of all disciplines) act as role models. Valuing work with users is essential and needs to be seen as a status activity. This allows senior clinicians to have a better understanding of user needs.

For more details contact:
jonathan.west@Oxleas.nhs.uk

Example 2: Using evidence based methods to inform workforce change

Trust: Birmingham and Solihull MH NHS Trust

Workforce development issue(s) addressed:

- Through a series of mergers, the Trust inherited a variety of arrangements for the delivery and staffing of its acute care services. In order to establish and meet user and carer needs in acute inpatient services, the Trust wished to standardise these arrangements as part of a major service and capital re-provision programme.
- The Trust wanted to better understand the capacity and capability of its acute inpatient nursing workforce, how they had been used in the past and within the resources available determine how staff roles could be redesigned to better meet user/carer needs

Approach adopted to workforce redesign:

A wide range of modernisation initiatives have been completed although they have not been part of a discrete project plan. These have included:

- Utilised the Acute Workload Calculator developed by CSIP to assess the resource, how it is being used and the needs of users and carers (see <http://www.westmidlands.csip.org.uk/mental-health/mental-health/acute-inpatient-programme-for-2007--08/acute-workload-calculator.html>).
- Piloted CCTA in order to redesign roles within inpatient teams.
- Utilised the Lean Thinking approach to think through a range of smaller initiatives which inform and are informed by the use of the Acute Workforce Calculator methodology



- Standardised shift patterns into a single type (there were 30 different shift patterns at the start of the process); developed an electronic rota system and rota management guidelines.
- Jointly created a programme to develop the capability of multi disciplinary clinical leadership in conjunction with Worcester University.
- Piloted a Modernising Medical Careers for acute care medical staff.
- Developed functionalised roles in some wards (e.g. medication management, discharge planning, etc) to free up nursing time.
- Moved to functional inpatient consultants for some of the wards.
- Participating in the STAR wards initiative.

What worked well?

- The Acute Workforce Calculator has been helpful in determining how to plan for staff role redesign on the acute wards and PICUs, although the implementation of this has yet to be undertaken.
- Developing the functionalised roles has worked well, although some staff could feel de-skilled as other roles become more specialised.
- Established a common baseline to use staffing resources associated directly with user and carer needs; and determine patient contact time spent on acute wards.
- A top down / bottom up approach has been successful in engaging all levels of staff.
- STAR Wards has been enthusiastically embraced by frontline clinical staff.
- The small step changes that have occurred from applying Lean Thinking, have been effective in enthusing clinical leaders.

What did not work so well?

- We have not yet been able to apply our range of initiatives as systematically as we would have liked across the Trust which would have maximised the impact. However, we have not constrained ideas either by taking a “one size fits all” approach.

Key benefits/outcomes:

- Improved service user-staff engagement.
- Better management of key events/issues e.g. medication management.
- Improved processes for ward staff management and coordination. For example; our electronic staffing management system works to ensure everyone is not taking holidays at the same time and leaving the wards staffed by agency nurses.

Lessons learnt:

- It is important to have a clear view of what you want to achieve at the start of the process in order to know when, and if, you have succeeded.
- It is essential to ensure you are focused on improving the experiences and outcomes for users and carers.
- You need to be aware of tangential issues that can affect patient outcomes e.g. through meeting legislation requirements such as European working time directive.
- A combination of approaches works best rather than using a single methodology.

For more details contact:
Ros.Alstead@bsmht.nhs.uk



Example 3: Using competency based frameworks to determine workforce design

Trust: Pennine Care NHS Trust

Workforce development issue(s) addressed:

- The project, commenced in January 2006, has looked at the skills and competencies required of the acute inpatient workforce in order to examine its development, the change process and implementation of New Ways of Working.
- Two acute inpatient units within the five boroughs of the Trust were the focus of this work with the intention of applying the findings to all acute inpatient services.

Approach adopted to workforce redesign:

- A project group, which lasted for six months, was established by the Executive Director of Nursing with wide ranging clinical, operational and training membership. There were no users or carers directly involved in this group although they were involved in the data collection processes and their views were sought on the acute care services.
- The project group initially gathered baseline data on usage, satisfaction (users, carer and staff), resource and skills analysis, resource utilisation and time and motion observational work.
- The care pathway through acute inpatient services was designed with timelines identified for key events within the “ideal patient journey.”
- Baseline data and the care pathway were used to identify the tasks and processes required of the acute inpatient workforce for the patient journey.

- The skills and competencies required were mapped against the National Occupational Standards (Skills for Health).

What worked well?

- Being informed by local data through the baseline exercise.
- Having a champion (Executive Director of Nursing) who has been fully involved in the project, driven the project and raised its profile.
- Having inputs from the right people (clinical and managerial) to make the necessary decisions.
- Having a person with dedicated time to manage the process has been invaluable.

What did not work so well?

- It would have been useful to have users and carers involved in the project group and care pathway development rather than solely in the collecting of baseline data.
- Mapping the National Occupational Standards against our identified tasks was hard, tedious and we are not sure how useful it will be in the long run. The Skills for Health database was difficult to use.

Key benefits/outcomes:

- From this process the project team identified the type of staff needed based on skills and competencies required and estimate the proportions within the acute care workforce.
- From this, the group were able to determine a shape of the workforce required for the inpatient service. Work is still underway to look at how this translates to whole time equivalents (WTE).



Lessons learnt:

- We needed to be clear about what we were trying to achieve and work within tight timescales. There is a fine line between involving people and getting the job done; you can involve too many people and get nowhere. There is a need for a degree of pragmatism.
- We found it hard at the start to see what the endpoint would look like. People were very uncomfortable about using a task focused approach.

For more details contact:

alison.kendall@penninecare.nhs.uk

Example 4: Developing an Urgent Care Pathway

Trust: Northumberland Tyne and Wear NHS Trust

Workforce development issue(s) addressed:

- South Tyneside had difficulties in recruitment and retention, particularly of medical staff.
- There were problems in staffing on the acute wards.
- Bed occupancy was high.
- The interface between the inpatient and crisis home treatment service was poorly developed.

Approach adopted to workforce redesign:

- Local clinical staff and managers met together and agreed to redesign local services into urgent and planned care streams.
- The urgent care pathway service includes crisis home treatment, acute day service, court liaison and A&E Liaison services. The

planned care pathway service covers all Community Mental Health Teams (CMHT) and Assertive Outreach Teams (AOT).

- Medical staff were reconfigured in a “quick and dirty” pragmatic way into urgent and planned care roles which have continued to develop over time.

What worked well?

- Though the redesign took place at a time of considerable organisational upheaval, the process was owned and developed locally, with structural changes taking place very quickly. The pathway has continued to be developed and refined in a multidisciplinary way
- The appointment of an dedicated psychologist for the pathway has improved access to psychological therapies.
- Urgent care consultant psychiatrists work across the whole pathway, from crisis home treatment to inpatient allowing for improved continuity of care.
- Co-location of all the urgent care services facilitated good working relationships.
- The acute day service provides a bridge between inpatient and home treatment.
- An Early Discharge Plan is completed for all admissions to identify what needs to happen for early discharge to take place.
- A weekly urgent care coordinating meeting gives an overview of activity in the pathway, promotes early discharge planning and best use of beds.

What did not work so well?

- Developing good consistency across urgent and planned care requires considerable work.
- A handwritten transition summary and integrated notes have helped improve



communication, but an electronic patient record is seen as the best outcome.

Key benefits/outcomes:

- There has been an improved focus in urgent care, with an increase in service user satisfaction being received in feedback.
- Bed usage has been reduced with improved uptake into home based treatment.
- Improved morale has led to improved recruitment and retention across all disciplines. The success of the project has led to other quality improvement projects such as AIMS accreditation.

Lessons learnt:

- Local multidisciplinary ownership allowed for very rapid change.
- However, structural change needs to be followed by regular reviews to problem solve and consolidate the redesign.
- Increasingly medical staff need to work as a medical team rather than working “alone together”.

For more details contact:
Phil.Hodes@stw.nhs.uk

Example 5: Integration of Acute inpatient Wards and Crisis Resolution and Home Treatment Staffing

Trust: Rotherham Doncaster and South Humber MH NHS Foundation Trust

Workforce development issue(s) addressed:

- Mental health services in North Lincolnshire

have undergone significant change in the last 3 years and aim to provide more accessible and appropriate services for people who have acute mental health needs.

- Implementation of New Ways of Working to ensure staff have the appropriate knowledge and skills to meet the need of service users.
- Developing skills for home treatment in the Crisis Resolution and Home Treatment Team.

Approach adopted to workforce redesign:

- Co-locating the Crisis Resolution and Home Treatment Team with the acute inpatient facility.
- Splitting of the two acute inpatient wards into one 7 day assessment / treatment ward and one treatment ward.
- Identifying a Consultant Psychiatrist with sole responsibility for the CRHT and 7 day assessment / treatment ward.
- Skills analysis of staff in order to identify adequate and appropriate skill mix across the service.
- Sharing the model across the mental health community.
- Involving service users and carers in the process.
- Engaging with the local universities in terms of skills based training for staff.

What worked well?

- The involvement of staff, service users and carers in designing the model as everyone “owned it”.
- As a service this was the first significant step into “New Ways of Working” and created



capacity in other parts of mental health services to develop further.

- Most of the staff embraced the new model as they could see very clear benefits for service users.
- The introduction of gate keeping for CRHT meant a smoother transfer into hospital based care for service users.

What did not work so well?

- Resistance from some staff groups had to be overcome, particularly around the gate keeping aspects.
- Changing one part of a mental health service had impacts on other areas of service, particularly community services, who did not always have sufficient capacity to respond.
- Resource issues in CRHT have impacted at times on their capacity for home treatment.

Key benefits/outcomes:

- Bed occupancy levels have greatly reduced on the inpatient unit.
- CRHT exceeded their home treatment targets for 07/08.
- Service users are having effective home treatment as an alternative to admission.
- Increased staff morale as they are working in new ways that increase job satisfaction.

Lessons learnt:

- We spend a lot of time in the NHS discussing change without doing a lot about it. On this occasion the team took an opportunity and just did it which has reaped huge benefits.

- Engaging staff, service users and carers at an early stage increases the chances of your project being successful.
- Everyone has to be clear about expectations and roles.

For more details contact:
Wendy.Fisher@rdash.nhs.uk

Example 6: Integrated Psychiatric Intensive Care Pathway and staffing Trust: Rotherham Doncaster and South Humber MH NHS Foundation Trust

Workforce development issue(s) addressed:

- The adult mental health services have recently moved from a district general hospital to a newly refurbished adult mental health unit and a new purpose built PICU and section 136 suite.
- To ensure that all wards had an appropriate skill mix and establishment.
- To ensure that all staff were appropriately qualified and experienced to run each ward area effectively.

Approach adopted to workforce redesign:

- Carried out a skills analysis of staff in order to identify adequate and appropriate skill mix across the service.
- Subsequently, all staff were interviewed, their preferences regarding their re-location were explored and any fears and expectations about the move to new premises were discussed.
- This included leadership roles across each ward.



- This was supported by a new service model that integrated the PICU as part of an acute pathway.
- Immediately prior to the move all staff attended a mixed induction day to further explore issues, be given more information and support whole service integration.

What worked well?

- Integrated staffing across the three wards allows for easier flow of service users to an area/ward most appropriate to their needs.
- The staff felt included throughout the project as the modern matron and nurse consultant attended staff meetings and had high visibility within the existing facilities.
- The induction days were informative, well received and allayed fears and preconceptions. They were constantly reviewed by the staff and new ideas and feedback were incorporated.
- Appointment of new staff to the service
- As part of the change process other professional groups were engaged, in particular, the police.

What did not work so well?

- There was some resistance from a minority of staff around the change process.
- Timescales for the build changed and became challenging for the staff development process.

Key benefits/outcomes:

- Increased levels of job satisfaction for staff, significant improvement to staff working lives.

- No delay in service users being cared for within a PICU environment and consequently no delay in their transfer back to an open acute ward.
- Therapies, engagement and other interventions continue uninterrupted throughout a service user's stay – a seamless experience for service users.

Lessons learnt:

- Never underestimate the importance of taking time to engage with large groups of staff about the detail that might concern them.
- There is never enough time to do everything, learn to prioritise.
- Be flexible. As the project progresses things change, take on new ideas, but get a balance with this so you don't lose your way.
- Be clear about roles, expectations and outcomes.
- Visit other areas and see what works and what doesn't. If it works use it, don't reinvent the wheel.

For more details contact:
Deborah.wildgoose@rdash.nhs.uk

Example 7: Developing an Ageless Service. incorporating an older people's mental health acute inpatient service into a working age unit
Trust: Sussex Partnership NHS Trust

Workforce development issue(s) addressed:

There were a number of workforce initiatives, which included:

- Defining the function of the acute inpatient wards.



- Introduction of the crisis resolution service.
- Improved whole systems working.

The results of the above measures had the following benefits:

- Enabled the closure of a working age acute ward at Meadowfield and release of funds for developing the Trust's early intervention service.
- The older people's functional mental health inpatient ward was sited in an environmentally poor unit. The decision was made to re-locate older peoples services into the working age unit.

Approach adopted to workforce redesign:

A project group was established and a project plan developed between the older people's mental health (OPMH) and working age adults mental health services (WAMHS):

- Agreement was reached regarding future management of unit at start of project. Single unit management arrangements were agreed.
- Ward was adapted to meet the needs of the OPMH client group.
- Human Resources – relocating working age staff and older people staff. Working age staff opting to work on the older age ward.
- Joint training and development.
- Agreeing equitable access to resources.
- OPMH ward managed by the working age modern matron and service manager.
- OPMH beds reduced from 24 to 18.

What worked well?

- OPMH ward now located in a significantly better physical environment.
- Privacy and dignity improved. Each service user

has their own bedroom and en-suite facilities.

- Integration between OPMH & WAMHS services:
- Shared management resources.
- Shared training & development.
- Shared assessment documentation.
- Shared skills. Each staff group has unique skills; able to use OPMH skills on WAMHS wards when required and visa-versa.
- Equal access to crisis resolution services.
- Environment is calm.
- Shared therapeutic activity programme.
- Positive feedback from service user and carers.
- Better integration between services.

What did not work so well?

- Initially the WAMHS way of working was regarded as being transferable to OPMH services. Over time WAMHS practices needed to change to become more sensitive to OPMH service user and service needs.
- Managers from OPMH found it difficult operating as managers in a unit which was predominantly for WAMHS.
- OPMH service had its own governance arrangements prior to transfer. Extra work had to be done to agree governance arrangements for OPMH ward.

Key benefits/outcomes:

- Promotion of equal access to a high quality inpatient environment.
- Inpatient unit became an adult unit, open to all with functional needs.



- Inpatient community reflected a more 'normal' community, with people from wider age range.
- Crisis resolution service offered equally to older people.

Lessons learnt:

- Need a clear understanding of operational responsibilities from the onset.
- WAMHS practice could not be completely transferred to OPMH service. Practice needed to change to reflect increased role of respite for carers/families supporting older people and inclusion of long term physical disability and pain in clinical risk assessment of older people.
- Creates a positive collaborative relationship between different services.
- Creates a focus on the best outcomes for the service user.
- The need to engage front line staff in the change.

For more details contact:

Seamus.watson@sussexpartnership.nhs.uk

Examples of New Ways of Working and new roles

Example 8: Implementing the functional split model for psychiatrists to develop the inpatient workforce

Trust: Suffolk Mental Health Partnership NHS Trust

Workforce development issue(s) addressed:

- The service system operated in a sectorised model with Consultants working across community and inpatient wards. The medical teams had heavy out-patient loads; community and inpatient teams were not functioning properly and services did not interface well.
- The inpatient wards were inefficient with multiple consultants and different styles of doing things; junior doctors spent most of their time working in the hospital settings and had poor knowledge of what teams were doing. Everyone was very busy and had little capacity to respond to GPs quickly.
- Hospital nurses experienced a range of difficulties with the main weekly focus being the traditional ward round which was very intimidating and unwieldy.
- Some admissions were inappropriate and others occurred as out of hours emergencies which led to an increasing use of out of area treatments.

Approach adopted redesign the acute care workforce:

- The first steps taken were a thorough reading of the literature followed by a visit to a service system that was undergoing radical transformation (Newcastle) to learn about its change processes. This instilled enthusiasm within the team and convinced them of the



need for major reform rather than something not very ambitious.

- Agreement was facilitated between the Consultants that they would specialise more than previously within community services and that inpatient work would be a separate role and be developed as a specialist service in its own right.
- A series of open discussions between medical staff determined who should work where based on their interests and strengths. This was a sensitive exercise which took some time to work through properly but was time well spent.
- Stock taking exercises looked at caseloads, team functioning and out-patient services. A self critical approach was adopted with questions about who was best placed to see individual service users, what outcomes there would be from other professionals working with them, why people were on the caseload if they were only being seen once every three months, etc. This drove the need to reshape services and practices.

What worked well?

- The attitude of the Chief Executive and Trust Board was supportive and gave the team the freedom to get on with the task.
- Discussions with consultants, junior doctors, nurses and other professional groups about their roles helped in gaining support and stimulating the change processes.
- The refocusing approach for better therapeutic engagement on the wards showed staff they could do more rewarding work and having dedicated medical staff attached to the wards greatly enhanced this.
- A small Trust team, with input from NIMHE, had a common agreement about making the system more efficient based on the structure of the day in acute wards.

A blueprint was developed and the team got on with it without project managers. The team came together to solve problems as and where they arose rather than meet for the sake of it.

What did not work so well?

- Interface issues between people / teams were problematic. Getting CPA care coordinators to fulfil their role within inpatient settings needs hard work to keep them engaged with users through the whole acute care pathway.
- MDTs only work if they interface well with each other and during the early stages some people struggled with this. It took a while for teams and professions to have a sense of collective responsibility rather than argue between themselves. Teams and individuals had to change so there was a lot of internal work within the teams but at times they forgot they had to relate to the rest of the system.
- Many community staff thought they would have greater autonomy but then at times became defensive about risk decisions. Teams need to develop a shared sense of decision making through good understanding and dialogue.

Key benefits/outcomes:

- Having the consultant and junior medical staff as an integral part of the inpatient team has improved decision making and encouraged joint problem solving whereas previously the nurses were dealing with a range of approaches because of working with multiple Consultants. Having dedicated and specialist inpatient consultants has led to higher standards and a much more organised approach to the work.
- There is no place to hide in an efficient service system. Staff have to be willing, turn up and



be up to date with what to do. If things are going properly staff will work openly within the team and learn from each other. The quality of the whole team and professionalism improves as a result; service users and families see this as the ward is calmer and more ordered and the needs of users are met in a timely fashion.

- There is daily planning meeting for the ward team every morning at 9am with the key hospital staff including nurses, occupational therapists, secretaries and medical staff. Every case is looked at and work priorities are agreed as a team. This is supplemented by a system of CPA reviews that are booked to take place on the ward over the week.

Lessons learnt:

- The inpatient services have to be staffed well. As the service becomes more efficient the work becomes more intense as more of the time is taken up with acutely ill people.
- Intense work with very ill people requires small bed numbers, ideally no more than 16 beds.
- An inpatient ward needs three doctors (consultant, middle and junior) to cope with the workload.
- Having a focused service area means staff (particularly doctors) have to be sharp and up to speed with a range of issues (e.g. MHA, MCA, basic physical care, etc).
- Previously people talked a lot but nothing ever happened because we tried to involve everyone. We were stifled by trying to develop the perfect system, which is impossible to achieve. Sometimes you just need to do it, mould things and address them as you go along. "Don't be frightened of trying to change things – just do it".

For more details contact:
albert.caracciolo@smhp.nhs.uk

Example 9: Implementing New Ways of Working in acute care services

Trust: Lancashire Care NHS Foundation Trust

Workforce development issue(s) addressed:

- We wanted to develop clinical and operational leadership skills in our modern matrons, ward managers and consultant psychiatrists.
- We needed a greater range of skills within the acute care workforce and were keen that the design of support, time and recovery roles in acute care did not mirror those of traditional nursing assistants.
- We wanted to improve the functioning of multidisciplinary teams within our acute care services.

Approach adopted to workforce redesign:

- We used elements of the Creating Capable Team Approach, outside agents from NIMHE and consultants to help plan a project to lead change.
- We took account of NWW and also the Policy Implementation Guides for Acute inpatient and PICU services along with the CMHT and CRHT guides. These were triangulated with the 10 Essential Shared Capabilities guidance on workforce.
- Took time out to look at the issues at the start of the process using external facilitators.
- Established NWW steering group to oversee the change which met monthly over an 18 month period. All professional and service groups were represented as were users and carers.
- Undertook a baseline audit of CPA coordinator caseloads to assess the intensity and equity of workload and to help inform the changes to inpatient care.



- Implemented the hospital / community split for consultant psychiatrists.
- Reviewed the role, function, grades and experience of junior doctors within acute inpatient services.

What worked well?

- The use of external facilitators worked particularly well as they were fully involved and committed to the change and guided teams and individuals in a way that local managers could not. They added capacity whilst also having a high degree of independence.
- Getting key groups together through the governance forums, such as consultant psychiatrists and ward managers worked well. Nevertheless there have been times when this has been a slightly rocky road.

What did not work so well?

- The community governance groups did not work so well as each team is so different and is very dependant on the style of the individual manager. However teams have now each drafted a service development action plan which is bringing them together and may see this governance group re-established at some point in the future.
- On occasion, we were unable to successfully appeal to some of the senior clinicians to recognise that change to inpatient services was necessary, e.g. how multidisciplinary teams and CPA care coordinators should operate and how more time needed to be made available for therapeutic activities with users. As a result, they sometimes required persuasion and clear direction.
- At times we suffered from a lack of a strict timetable which meant some decisions became protracted e.g. setting the date of

the move to inpatient only consultants.

- It was sometimes difficult to find the funding for the revamped medical posts in inpatient areas.

Key benefits/outcomes:

- New governance arrangements for inpatient services proved a powerful driver for change. Staff are empowered to address and resolve the day to day local issues relating to implementing change without having to refer to senior managers. The groups are chaired by the modern matron which is very empowering for them in their role as change agents.
- Each ward now also has its own regular management meeting with the ward manager and ward consultant.

Lessons learnt:

- Having a clear idea at the outset of what we wanted to achieve was important.
- Having external facilitators removed interpersonal issues between strong personalities within the services. Their unbiased support also helped us to sustain energy and focus upon the task to get it done.
- We would have benefited from developing a specific timetable or project plan.
- It is genuinely possible to work together, across professions and teams, and this can be demonstrably more effective than working in silos.
- We learned not to be afraid of drawing back from a position to reach a compromise – so long at the compromise is a win for the service user and not solely for professional self interest.

For more details contact:

john.keaveny@lancashirecare.nhs.uk



Example 10: Developing a new role – Associate Practitioner

Trust: Avon and Wiltshire Partnership NHS Trust

Workforce development issue(s) addressed:

Difficulties in the recruitment and retention of acute inpatient staff:

- In 2000 the Trust was projecting a major shortfall in mental health (RMN) nurses.
- Ward managers were concerned as they had put considerable resources into mentoring student nurses only to see them move into the community soon after qualification.
- Because of the geographical size of the Trust, there had been historical recruitment difficulties in some localities.
- Concerns about the need to develop a workforce that was fit for purpose in acute inpatient care.

Approach adopted to workforce redesign:

The ward managers wanted a system whereby people could be developed and retained in acute inpatient care. We wanted to develop an additional role within the workforce which could be supervised in acute care settings by mental health nurses to undertake a wide range of skilled tasks associated with acute inpatient care.

- A training programme for a new role of Associate Practitioner was developed collaboratively with the University of the West of England (UWE).
- The 12 month programme provided the ideal balance between academic knowledge and clinical practice skills development. Students worked exclusively in acute inpatient care

and were supported in situ by Practice Education Facilitators who were jointly managed between the Trust and University.

- Trainee staff worked for two days as a healthcare assistant and two days as a student Associate Practitioner on the ward and one day in training at the University.
- Funding for the training and clinical placement support given by the University was drawn from a combination of the Trust budget, Workforce Development Confederation and University of the West of England.

What worked well?

- The Associate Practitioners were fit for purpose as they trained in their own working environments. Healthcare Assistants saw the project as an opportunity for career development internally within the Trust.
- There was good ownership of the training and the role by ward staff as they were able to retain and develop skilled staff on acute inpatient wards.
- The collaborative approach with the University, particularly the Practice Education Facilitators working on the wards with the students, ensured there was an excellent balance between academic and clinical learning.

What did not work so well?

- The qualification is not transferable to other parts of the country as there is no national move to recognise or regulate the role despite encouragement centrally to develop this type of worker.
- The lack of a national approach to funding and regulation may inhibit such innovation in future. Because of this we are not able to plan this initiative in the long term.



- Initially the qualified nursing staff were nervous of the new roles and the implications for their practice in relation to delegated responsibility and the impact upon their registration should anything go wrong. In essence the registered nurses were concerned they would be held accountable for any mistakes the Associate Practitioners may make in practice.

Key benefits/outcomes:

- We were able to develop up to 40 very skilled staff who were ideally suited to working at a level between healthcare assistant and mental health nurse.
- The model works in motivating staff by providing a career pathway beyond healthcare assistant.
- The role works clinically and the model can be applied to community services too.
- It works in terms of pay structure for the students.

Lessons learnt:

- Securing long term funding is essential.
- Due to the lack of regulation, Trusts need to be confident with the competencies being developed in the staff and be prepared and able to indemnify the Associate Practitioners. Obtaining legal advice on this is important.
- Having a good mentorship system, through Practice Education Facilitators or other mechanisms is essential. This role evaluates well in student feedback.

For more details contact:
Patrick.McKee@awp.nhs.uk

Example 11: Developing a new role – Mental Health Practitioner Trust: Hampshire Partnership NHS Trust

Workforce development issue(s) addressed:

- The adult mental health services have undergone major expansion and reconfiguration over the past 5 years with the aim of providing more flexible, accessible and targeted therapies and services which are more community based.
- Critical to these plans are having the right number of staff, with the right knowledge and skills in the right place to deliver client focused and effective services.
- Shortage of suitably qualified nursing staff (particularly on inpatient wards), meant wards were, on occasion, being staffed by unqualified staff.
- Implementation of the European Working Time Directive and various related initiatives including: Knowledge and Skills Framework, New Ways of Working, the Capable Practitioner, etc.

Approach adopted to workforce redesign:

- The Chief Executive wanted to adopt a radically new approach by developing a way of attracting staff able to develop the knowledge and skills required, who would not otherwise consider a career in mental health.
- Staff in four provider organisations and the University of Southampton developed a new role (Mental Health Practitioner) and associated two year post-graduate diploma training programme.
- Staff are full time employees of the Trust and an ‘earn and learn’ apprenticeship approach is used with the trainee working in a single service setting for two years and being



released for 30 days to the University and 30 days to a collaborative placement (a related service). Trainees start in Band 3 and progress to band 4 at the end of year one and then move into Band 5 upon qualifying at the end of the second year.

- Skills development includes includes cognitive behaviour therapy (CBT), recovery approaches, hearing voices support, etc with the role supplementing the existing workforce and addressing staff shortages.
- Recruitment consists of a formal application, briefing day, written task and formal interview. Selection criteria include being a graduate, experience of mental health services as volunteers, users, carers or paid staff and demonstrating a real desire to work with people when they are distressed.

What worked well?

- Top level sign up between the five organisations was effective in developing the role and designing and delivering the training.
- The involvement of staff, users and carers in the process of developing the role and planning the training, grounding the role in the practical aspects of mental health care.
- National initiatives knitted well with the project e.g. the Capable Practitioners, Knowledge Skills Framework, National Occupational Standards – people saw that it delivered what was important to service users.
- The practice of other professions has changed over time and the Mental Health Practitioners have proved themselves to be a valued part of the workforce as it develops.

What did not work so well?

- Some of the partner providers withdrew over time, primarily because they were no longer

short of nurses and the incentive to adopt new ways of working decreased.

- There was some professional resistance at the start from nursing and other professions which took a while to overcome.

Key benefits/outcomes:

- The role is successful in attracting graduates who would not otherwise have considered a traditional career in mental health.
- Between 2003-8, over 1,300 graduates requested job packs/applications for 138 trainee mental health practitioner vacancies and over 60 are currently employed in the role in the Trust.
- A major, ongoing, research study indicates that the mental health practitioners have made a positive impact upon the care received by users of the service.

Lessons learnt:

- To undertake significant workforce development you need to take a calculated risk and just do it.
- You need to be clear about what you want the workforce to do.
- Changes in workforce will only work if there is Board level sign up within the organisation(s).
- Having a dedicated project manager to drive and implement was essential; they also needed skills in bringing people with them.
- It is essential to spend time with people, talking to them about their fears and concerns and help them to see the benefits of such significant change.
- You have to put service users needs before the needs of any profession – this is easy to



agree to but sometimes hard to achieve – everyone feels threatened by new roles!

- New Ways of Working can often mean extending traditional roles or changing processes rather than doing something really new.

For more details contact:
Allan.Jolly@hantspt-sw.nhs.uk

Example 12: Developing a discrete inpatient Therapeutic Team

Trust: Oxfordshire & Buckinghamshire MH Partnership NHS Trust

Workforce development issue(s) addressed:

- The Oasis Project ran from autumn 2005 through to spring 2007 and focused on workforce redesign of a 22 bed acute inpatient ward that served a deprived inner city area in Oxford.
- The ward was viewed as being a good ward with effective leadership and management. They wanted to free up ward nursing staff time in order to engage more flexibly and therapeutically with service users.

Approach adopted to workforce redesign:

- A “Therapeutic Team” service model was developed whereby Team nursing staff who would not be included in day to day ward staffing numbers would assertively deliver key interventions. The Team was planned to comprise four trained nursing staff who would each work with five or six service users.
- The ward skill mix was restructured to recreate the five new posts. This resulted in more healthcare assistants who were focused on personal care and patient

support. While overall there was a reduction in qualified nurses on the ward, their roles became more clearly defined. The qualified nurses focused on coordination, supervision and leadership, and the therapeutic team focused on case management, therapeutic engagement and intervention.

- The initial idea was germinated by the director of nursing and support was gathered from other senior colleagues. Direct buy-in with the ward nursing team was obtained through presentations and involving them in the development of the model.
- Staff were anxious about the reconfiguration although it was agreed there would be a minimum of two trained nurses per shift available in addition to the Therapeutic Team.
- A bespoke training programme for the Therapeutic Team was set up covering case management, CBT and family work skills development.
- A traditional project board methodology, including evaluation, was used to develop the service and included Human Resource staff as all the nursing posts on the ward were deemed new posts.

What worked well?

- The ward manager’s role was crucial and they provided the support and leadership to make the project work.
- A significant number of staff received well designed skills training, that has been positively evaluated.
- Ward team motivation to change practice and deliver a new style service was enhanced.

What did not work so well?

- The Therapeutic Team never got up to full strength and often functioned with only two



or three people. Other staff shortages meant they were also pulled back to ward duties from time to time.

- This was not a multidisciplinary project and therefore other disciplines were not as involved as they could have been.
- The project took a lot of time to gestate and sufficient momentum had not been created when there were threats to the project's success (e.g. losing the charismatic leader (ward manager) and funding cuts to the service). As a result, the project came to a close early.

Key benefits/outcomes:

- Anecdotal evidence from the Therapeutic Team staff was that this was the first real time they had felt they worked properly as a nurse in acute care.
- Consultant psychiatrists fed back how much better it was to have inpatient staff engaged and knowledgeable about their patients.

Lessons learnt:

- Change of this nature needs complete buy-in from operational managers of the service not just senior staff with a development brief.
- This type of change needs local clinical champions in the service. It needs to be seen by front line staff as their shared vision.
- There was an 18 month lead in from initial idea to getting the project up and running. This was too long; six months lead in would have probably seen the project get embedded while enthusiasm and energy were high.

- Sometimes you need external levers to enable change.

For more details contact:
Jon.Allen@obmh.nhs.uk

Example 13: Acute Inpatient Clinical Psychology Service Trust: Camden and Islington Foundation NHS Trust

Workforce development issue(s) addressed:

- Lack of clinical psychology provision to acute inpatient services dependant on very limited time available from community mental health teams psychologists.
- With the less-than-fit-for-purpose Waterlow Unit closing in 2004, directors and commissioners began to consider how to maximise the therapeutic potential of its replacement, the newly built Highgate Mental Health Centre.
- Ward-based staff members were not receiving much, if any, training in psychological interventions.

Approach adopted to workforce redesign:

- We determined that one consultant-level clinical psychologist (full-time) and one newly qualified clinical psychologist (half-time), aided in due course by clinical psychology trainees, should be sufficient to provide a service across five 16-bedded acute wards.
- Two clinical psychologists in psychotherapy were also commissioned to provide part-time sessional input to support ward-based teams and the lead professionals' management group with reflective practice and organisational support sessions.



- The Acute Inpatient Clinical Psychology Service was established in January 2005.

What worked well?

- The service collects referrals across wards twice weekly, endeavouring to assess individuals and/or families within one week and, optimally, to complete formulation-driven care plans and reports within two weeks.
- It provides a weekly cross-ward group called Leaving Hospital, focused on discharge-related goal-setting and community re-integration.
- Trainees run regular time-limited groups (Hearing Voices, Thinking Well), often with OTs, and conduct service-related research projects.
- The psychologists regularly co-lead, alongside MDT colleagues, formal training for ward staff on psychological components of practice (De-escalation, Community Meetings, Therapeutic Engagement) and participate in staff and service development projects
- A carers group, run in conjunction between psychology and nursing, is due to commence in July 2008. All ward teams were offered weekly reflective practice groups from the psychologist/psychotherapists.

What did not work so well?

- Initially, plans to divide the wards between the consultant and newly qualified psychologists risked diminishing choice (in particular, of therapist gender) and failing to use consultant-level clinical experience to address higher levels of risk and complexity.
- Facing difficulties attending CPAs and regularly feeding back to five separate ward teams, the service initiated half-hour slots in

each ward round, to discuss jointly held clinical work. This has served to enhance communication and to build a more multidisciplinary teamwork approach.

Key benefits/outcomes:

- Any inpatient service user in need of psychological evaluation/assessment, intervention or consultation will now very likely receive it.
- Staff members are increasingly engaging in psychological thinking and practice, and can refer on any inpatient they see fit, across all diagnoses and degrees of risk and complexity, when required.
- The introduction of this psychology input has, in many critical instances, reduced length of stay and rate of re-admission through more formulation-driven care and relapse prevention, demonstrating an effective investment-to-save initiative.

Lessons learnt:

- With relatively small investment, acute inpatients can receive the same access to full multidisciplinary, evidence-derived care as they would rightly expect from community services.
- Evidence-based psychological therapies can be adjusted to fit the requirements of short episodes and high levels of clinical acuity found on acute wards.
- Inpatient mental health care can gradually shift toward a more integrated, holistic and efficacious bio-psychosocial model of teamwork and service delivery, offering greater choice and satisfaction and better outcomes for service users.



- The anxieties of psychologists set to work into these challenging environments, as well as the apprehension of nursing, psychiatric and occupational therapy staff around incorporating psychology, are all surmountable with a sustainable psychology service delivery protocol, careful systems analysis and consultation and positive approaches to service implementation.

For more details contact:
John.Hanna@candi.nhs.uk

Example 14: Refocusing a ward team to develop a new women only ward **Trust: 5 Boroughs Partnership NHS Trust**

Workforce development issue(s) addressed:

- Development of a female acute admission ward (Weaver Ward) with an appropriately skilled workforce. This included reducing the ward from 20 to 14 beds and redeploying some of the existing male members of the staff.

Approach adopted to workforce redesign:

- Workforce planning was at the heart of the Trust's wider service redesign process.
- Weaver Ward participated as a pilot project to implement CCTA.
- A Trust-wide training needs analysis was undertaken to identify the skills necessary to practice safely in any given area of the Trust. This identified staff with various levels of training need and a programme to address this was established.
- Placement opportunities were created within other services.

- Fast track access to training courses at local Universities.
- The CCTA was followed strictly to the letter and facilitated by an external consultant.

What worked well?

- The process identified the mental and physical health needs of people in the area i.e. information on local demography, health, employment and social issues which helped tailor service development to local need.
- CCTA highlighted the skills and experience of the team, particularly the skills of the unqualified staff which were not being used (e.g. complementary therapies).
- Prioritising and gaining complete agreement amongst the team on the 20 top priorities for service development.
- Focusing on the role and function of the service helped clarify the core tasks the ward team should be concentrating on and what should best be delivered by or with others.

What did not work so well?

- The length of the process. The team found it hard to see the end point and what it would look like when they got there, particularly at Steps 2-3 when they were identifying areas for change.

Key benefits/outcomes:

- Based on the local needs assessment, the introduction of Well Women's Clinics, Healthy Eating and Women's Exercise Groups is being introduced to the ward routine.
- Better use of previously under- utilised staff skills



Lessons learnt:

- Step 1 of CCTA (preparation) is key to the success or failure of the approach. It needs driving by the facilitator and service / team manager to ensure everyone is informed about the process and committed to fully participating. This requires a lot of hard work to achieve.
- A collaborative relationship between the lead clinical and the ward manager was crucial to keeping everyone focused on the task and motivated.
- Facilitators need to be good at this role. It is not necessarily something that anyone can do. They need confidence, group management skills and personality to do this effectively.
- Board level support is needed to ensure the initiative is owned by the wider organisation.

For more details contact:

Mandy.Bailey@5boroughspartnership.nhs.uk

Example 15: Using Creating Capable Teams to develop a PICU workforce **Trust: Cumbria Partnership NHS Foundation Trust**

Workforce development issue(s) addressed:

- The aim of the project was to agree a PICU workforce development plan.
- Individual performance reviews had been completed for all staff including pharmacists, psychologists, medical and nursing but these were not really effective in terms of developing the workforce as they were constructed on an individual basis rather than from a team perspective.

- The staff within the team were not aware of the range of skills held by different members, and did not have a plan on how best to use them
- Other than knowing we wanted to change and having a broad idea of what we wanted we were not fixed on what this would look like or how it would happen.

Approach adopted to workforce redesign:

“As CCTA is led by local need and by the team it was like stepping into the dark in relation to how the service would develop.”

- Reviewed the current workforce and their competencies, seeing how this matched local needs and national guidance for PICU.
- We used the CCTA process and followed the method in the handbook closely; partly because we were a pilot site for CCTA.
- We went through all five steps in the CCTA process, the final step is the lengthiest and is ongoing.
- Involved service users, carers and representatives from the wider service.

What worked well?

- Once CCTA has been done once by facilitators and a team it is easy to adapt. You can use parts of the process to develop aspects of team working but it is essential to do it step by step as in the handbook on the first occasion to gain a good grasp of the methodology used.
- The involvement of individuals who offered a different perspective than those who worked on the unit.
- The team (in its widest sense – including psychiatrists, psychology, occupational



therapists, pharmacists, service users and carers etc.) owned the outcomes.

- Having a former service user involved and accepted as a member of the team during CCTA was very helpful in the process and provided tremendous insights highlighting both good practice and deficits in the service.
- Staff ownership of the redesign process encouraged them to start implementing things as soon as they were raised in the CCTA sessions rather than wait until the action plan was developed at the end of Step 4.

What did not work so well?

- Step 1 did not work as well as it might have done. There is a need to ensure adequate emphasis and time is given to reading and understanding the literature at the start of the process.
- Step 3 can be complicated and we came out with 19 priority changes or needs. This caused anxiety in the team during this session. Therefore it was agreed as a team to review and prioritise them.

Key benefits/outcomes:

- Deficits in the service were identified, such as the lack of availability or access to physical activity, and addressed in the action plan.
- Many of the staff had life skills they brought to the team but which were only recognised through using CCTA.. e.g., one member of the team had previously managed their own business and was able to transfer these skills easily to the ward environment; another had worked previously in an admin role and is now using those skills on the unit.

- It produced fantastic materials and information about the team which highlighted their skills and abilities. Although it is not a team-building exercise it has had this effect.
- The team learned about themselves as individuals, local and national requirements of PICUs, gained a shared vision of what was needed and the population area they served.
- They also learned about budgets and how these are managed (including all of the staff costs), associated staffing and financial limitations and how they can be used to develop the workforce.
- For the considerable time and effort involved the benefits far outweighs the time commitment.

Lessons learnt:

- It is essential to have an experienced and impartial CCTA facilitator.
- Step 1 requires time and effort from the facilitators for the process to work.
- It is important there is not too much of a top down approach as the team needs to get to things themselves rather than with managers in the room.
- CCTA needs to happen regularly as service systems and workforces are dynamic and this locates them within systems. It helps teams feel in control of their work and their role in the system and also helps motivate them.

For more details contact:
Pam.travers@cumbria.nhs.uk



5 Learning the Lessons from the Experiences of Acute Workforce Redesign

This section of the workbook summarises the lessons learnt (and questions raised) from the experiences of the 15 Trusts that provided the examples in Section 4. These examples offer a valuable learning opportunity. Information on these and other examples is held on the Virtual Ward website and you are encouraged to submit further examples of your own workforce development initiatives to help share learning on acute workforce innovation.

Drivers for change that influence acute care workforce development

- Improving the experience and effectiveness of inpatient care for service users and carers.
- Needing to better attend to the gender, cultural, physical health and social inclusion needs of service users and to better respond to the diverse needs of local populations.
- Difficulties for inpatient wards, particularly in respect of recruiting, retaining and developing the skilled workforce required to provide effective safe and therapeutic care for acutely ill service users.
- The need to move on from traditional and isolated ways of working as they were viewed as not delivering what was required by users, carers and staff. All of the services had a strong desire to modernise and support the workforce in matching skills and practice to the needs of acute care service users and carers.

- The introduction and development of CRHT services, while presenting very real challenges regarding retaining staff skills in inpatient services, provided opportunities for better defined care pathway functions and innovative workforce development.
- The need for integrated working and 24/7 co-ordination across care pathway services
- Improving the amount of staff time spent with service users, securing key clinical inputs to acute inpatient wards and better provision of evening and weekend activities.
- Service redesign and capital investment in new /refurbished facilities. Developing services and staff need to be seen as part of the same process.

Key success factors which enable the process of acute care workforce change

- Executive/ Board level interest and support prioritising the need for acute care service improvement.
- An emphasis on service user and carer experience and their active involvement in defining objectives.
- Developing a 'can do' culture and a structure which supports change and continuous improvement.



- Affirming and acknowledging the skills of existing staff (included unused skills and life skills) and identifying skill gaps.
- Active leadership and collaboration by senior clinical and management staff in and across the acute care services is vital.
- Having a clear focus on the vision, purpose and functions of the proposed service and associated workforce change and getting sign up to the project by all those that it would affect. A “top down / bottom up” approach was evident in many of these services.
- Focusing on key events and interfaces and being very specific about the who, what where and when of proposed arrangements and associated new ways of working.
- Paying specific attention to the interface issues between components of the acute care pathway in order to ensure care pathway consistency and coherence. A whole system approach can identify key points in the pathway that need focused attention and provide opportunities for innovative workforce development across pathway services.
- An open approach based on evidence, baseline data, audit and feedback.
- The ability of professional groups or individual service components to see the bigger picture rather than their own sphere of practice and consequently avoid being “precious” or territorial.
- Use of workforce planning methodologies and tools such as CCTA.
- A pragmatic approach – learning by doing. There needs to be a balance between involving people and getting the job done. Small changes can make a big difference.
- Clear management of the workforce redesign process with a project group structure, dedicated resources and timescales. These need to be reviewed regularly for effectiveness and to maintain momentum.
- An openness to learning from elsewhere and to partnership opportunities.
- An empowered Acute Care Forum can make a valuable contribution to enhancing involvement, communication and the sustainability of workforce innovation.

Themes to consider in your acute care workforce development

- Is there sufficient clarity regarding the overall acute care pathway and desired service model?
- Are current arrangements and working practices able to prioritise the necessary urgent clinical focus?
- Are there clear management and clinical leadership arrangements in place for acute care services? Would a functional split between acute/ community or urgent care /planned care help?
- Could concentrating expertise at key points/events on the care pathway improve service outcomes-e.g. gatekeeping, admission/assessment, daily review?



- Do present service and associated staff role definitions facilitate the most effective matching of staff skills to service user and carer needs?
- Are the specialist skills of the current acute care staff well defined and deployed across the care pathway?
- Are service, workforce and management arrangements best placed to benefit from synergies between service components?
- Could changes in traditional working practices and times assist the provision of evening and weekend therapeutic and recreational activities?
- How well does the staff profile match local population needs?
- How might the development of New Ways of Working and /or new roles help acute care services better attend to social issues impeding discharge and recovery?
- What partnership opportunities are available to help recruit, retain and develop your acute care workforce?
- Have you carried out an equality impact assessment of any workforce changes you wish to make?
- Do current role/service definitions guarantee key inputs (psychology, pharmacy, physiotherapy...) to acute care services and specifically inpatient wards?
- How will you embed and sustain workforce innovation across the service?



6 Conclusion

It is hoped this workbook provides encouragement, support and practical assistance to those who are tasked with meeting the challenge of developing an acute care workforce with the skills and competencies to deliver an effective service based on user and carer needs.

It should also provide inspiration from the services who have shared their experiences here in order that others can learn the lessons from their efforts and be of benefit to services developing their action plans following the recent Healthcare Commission review.



Glossary

ACF	Acute Care Forum	MHPIG	Mental Health Policy Implementation Guide
A&E	Accident and Emergency	NAO	National Audit Office
AIMS	Accreditation for Acute Inpatient Mental Health Services (Royal College of Psychiatrists scheme)	NAPICU	National Association of Psychiatric Intensive Care Units
AOT	Assertive Outreach Team	NICE	National Institute for Health and Clinical Excellence
BME	Black and Minority Ethnic	NIMHE	National Institute for Mental Health in England
CAMHS	Child and Adolescent Mental Health Services	NPSA	National Patient Safety Agency
CBT	Cognitive Behaviour Therapy	NWW	New Ways of Working
CCTA	Creating Capable Teams Approach	OPMH	Older People's Mental Health
CMHT	Community Mental Health Team	OT	Occupational Therapist
CNO	Chief Nursing Officer	PCT	Primary Care Trust
CPA	Care Programme Approach	PICU	Psychiatric Intensive Care Unit
CRS	Crisis Resolution Service	RCPsych	Royal College of Psychiatrists
CRHT	Crisis Resolution Home Treatment	RMN	Registered Mental Health Nurse
CSIP	Care Services Improvement Partnership	SCMH	Sainsbury Centre for Mental Health
DH	Department of Health	SMT	Senior Management Team
ESC	Essential Shared Capabilities	STR	Support Time and Recovery Worker
GP	General Practitioner	TPWP	Team Profile and Workforce Plan
HC	Healthcare Commission	UWE	University of West England
LDP	Local Development Plan	VW	Virtual Ward website
LDPR	Local Development Plan Review	WAMHS	Working Age Mental Health Service
MDT	Multi-Disciplinary Team	WTE	Whole Time Equivalent
MHA	Mental Health Act		
MH	Mental Health		



Summary of examples and contact details

No	Workforce initiative	Organisation	Email contact
1	Using audit and evidence to drive acute care workforce redesign	Oxleas NHS Foundation Trust	<i>jonathan.west@Oxleas.nhs.uk</i>
2	Using evidence based methods to inform workforce change	Birmingham and Solihull Mental Health NHS Trust	<i>Ros.Alstead@bsmht.nhs.uk</i>
3	Using competency based frameworks to determine workforce design	Pennine Care NHS Trust	<i>alison.kendall@penninecare.nhs.uk</i>
4	Developing an Urgent Care Pathway	Northumberland, Tyne and Wear NHS Trust	<i>Phil.Hodes@stw.nhs.uk</i>
5	Integration of Acute inpatient Wards and CRHT Staffing	Rotherham Doncaster and South Humber MH NHS Foundation Trust	<i>Wendy.Fisher@rdash.nhs.uk</i>
6	Integrated Psychiatric Intensive Care Pathway and staffing	Rotherham Doncaster and South Humber MH NHS Foundation Trust	<i>Deborah.wildgoose@rdash.nhs.uk</i>
7	Developing an Ageless Service	Sussex Partnership NHS Trust	<i>seamus.watson@sussexpartnership.nhs.uk</i>
8	Implementing the functional split model for psychiatrists to develop the inpatient workforce	Suffolk Mental Health Partnership NHS Trust	<i>albert.caracciolo@smhp.nhs.uk</i>
9	Implementing New Ways of Working in acute care services	Lancashire Care NHS Foundation Trust	<i>john.keaveny@lancashirecare.nhs.uk</i>
10	Developing a new role: Associate Practitioner	Avon and Wiltshire Partnership NHS Trust	<i>Patrick.McKee@awp.nhs.uk</i>
11	Developing a new role: Mental Health Practitioner	Hampshire Partnership NHS Trust	<i>Allan.Jolly@hantspt-sw.nhs.uk</i>
12	Developing a discrete inpatient Therapeutic Team	Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust	<i>Jon.Allen@obmh.nhs.uk</i>
13	Acute Inpatient Clinical Psychology Service	Camden and Islington Foundation NHS Trust	<i>John.Hanna@candi.nhs.uk</i>
14	Refocusing a ward team to develop a new women only ward	5 Boroughs Partnership NHS Trust	<i>Mandy.Bailey@5boroughspartnership.nhs.uk</i>
15	Using CCTA to develop a PICU workforce	Cumbria Partnership NHS Foundation Trust	<i>Pam.travers@cumbria.nhs.uk</i>



References

Baguley, I., Alexander, J., Middleton, H. & Hope, H. (2007) **New ways of working in acute inpatient care: a case for change.** *Journal of Mental Health Training, Education and Practice.* 2:2, 43-52.

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A. & Warren, J. (2005) **The nature and purpose of acute psychiatric wards: The Tompkins Acute Ward Study.** *Journal of Mental Health.* 14:6, 625-635.

Care Services Improvement Partnership (2005) **Everybody's Business: Integrating mental health services for older adults**
<http://www.olderpeoplesmentalhealth.csip.org.uk/everybodys-business/download-documents.html>

Care Services Improvement Partnership/
Department of Health (2006) **A National Survey of Crisis Resolution Teams in England.**
<http://www.nimhe.csip.org.uk/silo/files/crtexecutivesummarydoc.doc>

Care Services Improvement Partnership/Department of Health/NHS Confederation (2008) **Laying the Foundations for Better Acute Mental Health Care: A service redesign and capital investment workbook.**
<http://www.nimhe.csip.org.uk/silo/files/csip-finalpdf.pdf>

Care Services Improvement Partnership:
National Institute for Mental Health in England (2005) **Acute workload calculator.**
<http://www.westmidlands.csip.org.uk/mental-health/mental-health/acute-inpatient-programme-for-2007--08/acute-workload-calculator.html>

Care Services Improvement Partnership:
National Institute for Mental Health in England (2006) **Our Choices in Mental Health: A Framework for Improving choice for People Who Use Mental Health Services and Their Carers.**

<http://www.csip-plus.org.uk/CPT/Our%20Choices%20Doc%20-%20Final.pdf>

Care Services Improvement Partnership:
National Institute for Mental Health in England (2007) **Age Equality: What does it mean for older people's mental health services?**
Guidance note. *Everybody's Business.*
<http://www.olderpeoplesmentalhealth.csip.org.uk/silo/files/age-equality-guidance-note-pdf.pdf>

Care Services Improvement Partnership:
National Institute for Mental Health in England (2007) **A Positive Outlook: A good practice toolkit to improve discharge from inpatient mental health care.**
<http://www.nimhe.csip.org.uk/silo/files/apositiveoutlookpdf.pdf>

Care Services Improvement Partnership:
National Institute for Mental Health in England (2007) **Onwards and Upwards: Sustaining service improvement in acute care.** Making the most of the Healthcare Commission 2006/07 acute inpatient service review.
<http://www.nimhe.csip.org.uk/silo/files/onwardsandupwardshandbookpdf.pdf>

Care Services Improvement Partnership and Royal College of Nursing (2008) **Informed Gender Practice: Acute mental health care that works for women.**
<http://www.snpearstesting.org/InformedGenderPractice-web%20version.pdf>



Department of Health (1999) **A National Service Framework for Mental Health.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

Department of Health (1999) **Effective care co-ordination in mental health services: modernising the care programme approach – a policy booklet.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009221

Department of Health (2000) **Safety, Privacy and Dignity in Mental Health Units.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007095

Department of Health (2001) **Mental Health Policy Implementation Guide.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009350

Department of Health (2002) **Mental Health Policy Implementation Guide: Adult acute inpatient care provision.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009156

Department of Health (2002) **Mental Health Policy Implementation Guide: Dual diagnosis good practice guide.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058

Department of Health (2002) **Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units and Low Secure Environments.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010439

Department of Health (2002) **National Suicide Prevention Strategy for England.**

<http://www.virtualward.org.uk/silo/files/suicide-prevention-strategy.pdf>

Department of Health (2003) **Mainstreaming gender and women's mental health: implementation guidance.**

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4072067&chk=uuBKuS

Department of Health (2004) **Mental Health Policy implementation Guide: Developing positive practice to support the safe and therapeutic management of aggression and violence in mental health inpatient settings.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087136

Department of Health (2004) **National Service Framework for Mental Health: 5 years on.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4099120

Department of Health (2004) **The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169



Department of Health (2005) **Mental Health and Deafness – Towards Equity and Access: Best practice guidance.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103995

Department of Health (2005) **Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett.**

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

Department of Health (2005) **Independence, Well-being and Choice.**

http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106478.pdf

Department of Health (2005) **New ways of working for psychiatrists: Enhancing effective person-centred services through new ways of working in multi-disciplinary and multi-agency contexts. Final Report 'but not the end of the story'.**

<http://www.newwaysofworking.org.uk/pdf/NWW%20for%20Psychiatrists%20Final%20Report.pdf>

Department of Health (2006) **Dual diagnosis in mental health inpatient and day hospital settings.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649

Department of Health (2006) **From Values to Action: The Chief Nursing Officer's review of mental health nursing.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133839

Department of Health (2006) **Our Health, Our Care, Our Say: A new direction for community services.**

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/OurHealthOurCareOurSay/fs/en>

Department of Health (2006) **Reviewing the Care Programme Approach.**

<http://www.nimhe.csip.org.uk/cpa>
http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_063354

Department of Health (2007) **Breaking down barriers. Clinical Case for Change: Report by Louis Appleby, National Director for Mental Health.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074579

Department of Health (2007) **Commissioning Framework for health and well-being.**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Department of Health (2007) **Creating Capable Teams Approach.**

<http://www.newwaysofworking.org.uk/ccta.aspx>

Department of Health (2007) **Mental Health: New Ways of Working for Everyone.**

Developing and sustaining a capable and flexible workforce. Progress Report.

<http://www.newwaysofworking.org.uk/pdf/progressreportpdfapril2007.pdf>

Department of Health (2007) **Mental Health: New Ways of Working for Everyone: A best practice implementation guide.**

http://www.newwaysofworking.org.uk/pdf/1002_2NWW%20for%20Everyone%20Implementation%20Guide.pdf



Department of Health (2007) **Privacy and Dignity: a report by the Chief Nursing Officer into gender mixing in hospitals.**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074543

Department of Health (2007) **Single Equality Scheme 2007-2010.**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075463

Department of Health (2008) **Refocusing the Care Programme Approach: policy and positive practice guidance.**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

Department of Health (2008) **Code of Practice: Mental Health Act 1983 – revised 2008.**
<http://mhact.csip.org.uk/news/code-of-practice>

Department of Health/Care Services Improvement Partnership (2006) **Guidance Statement on Fidelity and Best Practice for Crisis Resolution Teams.**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063015

Department of Health, Valuing People Support Team (2004) **Green Light for Mental Health: how good are your services for people with learning disabilities?**
<http://www.library.nhs.uk/learningdisabilities/ViewResource.aspx?resID=260448>

Gilbert, P. (2008) **Guidelines on spirituality for staff in acute care services Staffordshire University.**
<http://www.nimhe.csip.org.uk/silo/files/spiritualitybooklet3pdf.pdf>

Greenwood, P., Ryan, T., Keaveny, J & Deo, R (2007) **Supporting Change: Implementing New Ways of Working in East Lancashire.** *Mental Health Review Journal.* 12:3, 10-14.

Hardcastle M, Kennard D, Grandison S and Fagin L (2007). **Experiences of mental health in-patient care.** Routledge (ISPS series).
<http://www.isps.org/FileArchive/80/inpatientbookflyer&orderform.pdf>

Healthcare Commission (2007) **2006/07 Acute inpatient mental health review: Final assessment framework.**
http://www.healthcarecommission.org.uk/_db/_documents/Final_assessment_framework.pdf

Healthcare Commission (2008) **The Pathway to Recovery: A review of NHS Acute Inpatient mental health services.**
http://www.healthcarecommission.org.uk/_db/_documents/The_pathway_to_recovery_200807251020.pdf

Healthcare Commission/Commission for Social Care Inspection (2007) **No voice, no choice: A joint review of adult community mental health services in England.**
http://www.healthcarecommission.org.uk/_db/_documents/Communiticy_mental_health_-_full_report.pdf



Healthcare Commission/Mental Health Act Commission (2007) **Count Me In 2007 Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales.**

http://www.healthcarecommission.org.uk/_db/_documents/Count_me_in-2007.pdf

Healthcare Commission/Royal College of Psychiatry. (2008) **The National Audit of Violence (2006-2007) Final Report: Working age adult services.**

<http://www.rcpsych.ac.uk/PDF/!removed--WAA%20Nat%20Report%20final%20for%20Leads%2010%2012.pdf>

Janner, M (2006). **Star Wards: Practical ideas for improving the daily experiences and treatment outcomes of acute mental health inpatients.**

<http://starwards.org.uk/pdfs/starwards.pdf>

Macmillan, F and Adams, N (2005) **Acute Adult Mental Health Care; Increasing capacity of 24 hour acute care: Report for Acute Care Forum.**

www.nimhe.csip.org.uk/silo/files/capacity-demandeffectiveness-nick-adams-21-jluy-2005doc.doc

Middleton, H., Baguley, I., Alexander, J. & Bell, L. (2007) **The Role of Consultant Psychiatrist in the Acute Care Setting: A report to the Acute Inpatient Mental Health Project Board from the Acute Care Workforce sub-group.** Unpublished report.

Munro, S. & Baker, J. (2007) **Outcomes associated with skill mix interventions in acute mental health wards: a synthesis of evidence.** *Journal of Mental Health Training, Education and Practice.* 2:3, 25-33.

National Audit Office (2007) **Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment Services.**

http://www.nao.org.uk/publications/nao_reports/07-08/07085.pdf

National Institute for Health and Clinical Excellence (2003) **NICE guideline: Schizophrenia: The Management of Symptoms and Experiences of Schizophrenia in Primary and Secondary Care.**

<http://guidance.nice.org.uk/CG1/?c=91523>

National Institute for Health and Clinical Excellence (2004) **NICE guideline: Self-harm: The Short term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary care.**

<http://guidance.nice.org.uk/CG16/?c=91523>

National Institute for Health and Clinical Excellence (2005) **NICE guideline: The short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments.**

<http://guidance.nice.org.uk/CG25/niceguidance/pdf/English>

National Institute for Health and Clinical Excellence (2007) **NICE guideline amended: Depression: The Management of Depression in Primary and Secondary Care.**

<http://guidance.nice.org.uk/CG23/niceguidance/pdf/English>

National Institute for Mental Health in England (2004) **The Capable Acute Care Forum.**

<http://www.nimhe.csip.org.uk/silo/files/capableacutecareforumpdf.pdf>



National Institute for Mental Health in England/Mental Health Foundation (2003) **Inspiring Hope: Recognising the Importance of Spirituality in a Whole Person Approach to Mental Health.**
http://bipolarworld.net/pdf/spirituality_project.pdf

National Institute for Mental Health in England/Mentality (2004) **Healthy Body Healthy Mind: Promoting Healthy living for people who experience mental health problems. A Guide for people working in inpatient services.**
<http://213.121.207.229/upload/Healthy%20Body,%20healthy%20Mind-Inpatient%20.pdf>

National Institute for Mental Health in England/Sainsbury Centre for Mental Health (2004) **Acute Inpatient Mental Health Care: Education, Training and Continuing Professional Development for All.**
<http://www.virtualward.org.uk/silo/files/acuteinpatientcarepdf.pdf>

National Institute for Mental Health in England/Sainsbury Centre for Mental Health Joint Workforce Support Unit (2004) **The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce.** London, DH.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169

National Patient Safety Agency (2006) **With safety in mind: mental health services and patient safety.** Patient Safety Observatory Report 2.
<http://www.virtualward.org.uk/silo/files/npsa-safety-in-mental-health-0906pdf.pdf>

Office of the Deputy Prime Minister Social Exclusion Unit (2004) **Mental Health and Social Exclusion. Social Exclusion Unit Report.**
<http://www.nimhe.csip.org.uk/silo/files/mentalhealthreportpdf.pdf>

Rae, M (CSIP NIMHE 2007) **Review of open door policy in acute inpatient wards: A discussion paper.**
<http://www.nimhe.csip.org.uk/silo/files/reviewofopendoorsfinalapril20072doc.doc>

Royal College of Psychiatry. **Accreditation for Acute Inpatient Mental Health Services (AIMS).**
<http://www.rcpsych.ac.uk/AIMS>

Star Wards – a service user led initiative to improve positive user engagement.
www.starwards.org.uk

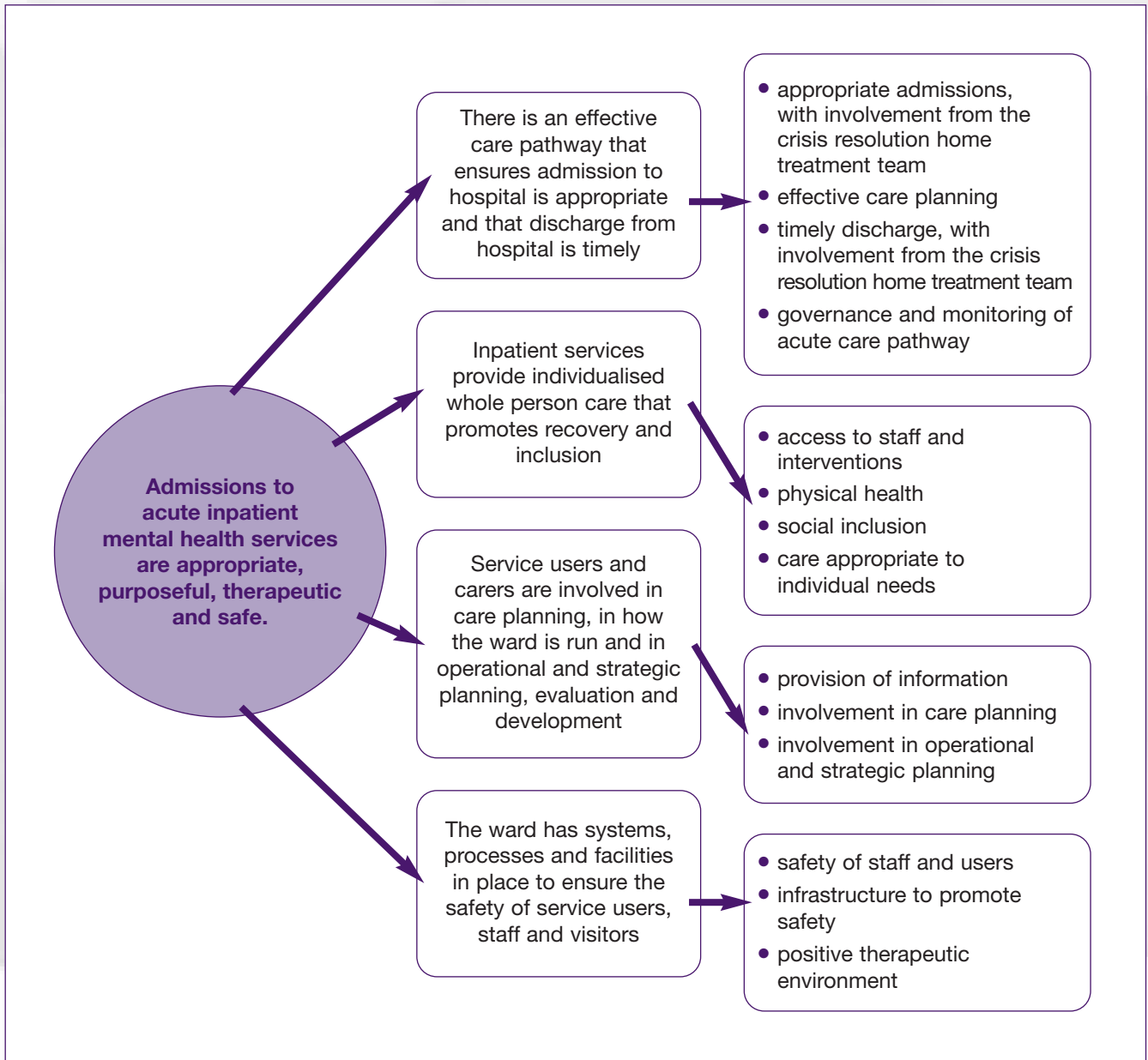
Star Wards 2 The Sequel
http://starwards.org.uk/sw2/SW2_lowres.pdf

Virtual Ward
www.virtualward.org.uk



Appendix 1 Healthcare Commission Assessment Framework Summary

The following diagram gives a summary of the Healthcare Commission's assessment framework which underpins their 2007 acute inpatient service review:



Appendix 2 Tools, Resources and Sources of Information

Tools and resources

Workforce development – New Ways of Working

NWW is about changing the practice of the current workforce; developing extended roles beyond the scope of current professional practice and bringing in new people to the workforce in new roles, at assistant and practitioner levels. There is no single model for NWW; it is simply about making the best use of the skills in the workforce to meet need in a cost effective way. The New Ways of Working website provides a wide range of guidance and support materials to help service consider how they might develop their acute inpatient workforce.
<http://www.newwaysofworking.org.uk/>

Team development – Creating Capable Teams Approach

The Creating Capable Teams Approach is intended to help local health and social care services at a multidisciplinary team level, to review their skill mix and refine their learning and development needs on the basis of service user and carer need. New Ways of Working, as set out in the companion document Mental Health: New Ways of Working for Everyone is intended to support and underpin this process.
<http://www.newwaysofworking.org.uk/ccta.aspx>

Leadership – The ‘whole systems’ model for leadership & management

Skills for Care (2006) The ‘whole systems’ model for leadership & management. Leeds, Skills for Care.
[http://www.topssengland.net/files/Prod2%2006webedn\(1\)\(1\).pdf](http://www.topssengland.net/files/Prod2%2006webedn(1)(1).pdf)

Workload planning and development

Acute Workload Calculator

This helps teams estimate the workload and the required staffing level to deliver care to their clients based on a set of standardised care activities and number of clients that are set locally.
<http://www.westmidlands.csip.org.uk/mental-health/mental-health/acute-inpatient-programme-for-2007--08/acute-workload-calculator.html>

Workload planning – The Acuity/Dependency Tool

The Acuity/Dependency tool has been developed to help NHS hospitals measure patient acuity and dependency to inform evidence-based decision making on nursing staffing and workforce. Although developed originally for acute physical healthcare it may be useful in supporting inpatient mental health service development.
<http://aunuh.org.uk/members/PCP.htm>



Workforce planning and development

Workforce design and development: a report on the NIMHE National Workforce Planning Pilot Programme (WPPP).

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136571

A range of mental health related workforce development support tools are available at the Healthcare Workforce site:

<http://www.healthcareworkforce.nhs.uk/mentalhealth.html>

Competency based staff development

Amongst other materials the Skills for Health website contains a wealth of competency based materials that are useful for workforce development:

<http://www.skillsforhealth.org.uk/>

Change management

Iles V & Sutherland K (2001) Organisational Change: A Review for Health Care Managers, Professionals and Researchers. London: NCCSDO.

<http://www.sdo.lshtm.ac.uk/files/adhoc/change-management-review.pdf>

Cameron, M., Cranfield, S., Iles, V. & Stone, J. (2001) Making Informed Decisions in Change. London: NCCSDO.

<http://www.sdo.lshtm.ac.uk/files/adhoc/change-management-booklet.pdf>

Iles, V. & Cranfield, S. (2004) Developing change management skills. London: NCCSDO.

<http://www.sdo.lshtm.ac.uk/files/adhoc/change-management-developing-skills.pdf>

Quality, efficiency and engagement

Lean thinking

Lean is an approach to improve flow and eliminate waste developed by Toyota. Lean is basically about getting the right things to the right place, at the right time, in the right quantities, while minimising waste and being flexible and open to change. Lean thinking is being taken up by many areas of health care. Tools have been developed that address workplace organisation, standardisation, visual control and elimination of non-value added steps are applied to improve flow, eliminate waste and exceed customer expectations.

http://www.institute.nhs.uk/quality_and_value/lean_thinking/lean_thinking.html

<http://www.leanuk.org>

Releasing time – The Productive Ward

The Productive Ward is an approach designed to release time for ward nursing staff to spend on therapeutic work with users. It provides a toolkit incorporating a range of tools within 14 modules to be used collectively rather than stand alone devices.

http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

NHS Modernisation Agency Improvement Leaders' Guides

The highly successful Improvement Leader Guides were originally created in 2002 in order to share the tools and techniques that have had the greatest improvement effect. They were expanded and reissued in 2005 and provide an excellent course in the core service improvement methodology and how to apply it.



There are 13 booklets in the series which can be downloaded from http://www.institute.nhs.uk/building_capability/building_improvement_capability/improvement_leaders%27_guides%3a_introduction.html

The booklets are grouped into 3 themes:

- General improvement skills – which includes Improvement knowledge and skills, Process mapping, analysis and redesign, Involving patients and carers, Working with groups, Evaluating improvement
- Process and systems thinking - which includes Measurement for improvement, Matching capacity and demand, Working in systems, Improving flow
- Personal and organisational development – which includes Managing the human dimensions of change, Building and nurturing an improvement culture, Redesigning roles, Leading improvement

CSIP 10 High impact changes for Mental Health Services

The 10 High Impact Changes document was first launched in 2004 by the NHS Modernisation Agency. Based on evidence gained from practice, the document focused on areas of service improvement that have the biggest impact and can achieve maximum benefit for service users and carers and on clinical outcomes, service delivery and staff and their organisations. The CSIP guide extended the scope of the original work to make them relevant for mental health and took a “whole systems approach” to services that support people with mental health problems. Copies can be downloaded from: <http://www.nimhe.csip.org.uk/silo/files/10-hics-full-publication.pdf>

A further document High impact changes for health and social care was published in 2008 which can be downloaded from: <http://www.csip.org.uk/silo/files/hics-doc-11th-march.pdf>

Six Sigma

The core of the Six Sigma methodology, originally developed by Motorola, is a data-driven, systematic approach to improving processes and quality with a focus on customer impact. Six Sigma strives for perfection. Since it was originally developed, Six Sigma has become an element of many Total Quality Management initiatives. There are some similarities with Lean Thinking but each has a different value base – production v quality. For more information go to <http://www.sixsigmagroup.co.uk>

Delayed discharges

“NIMHE’s Acute Care programme has published a toolkit in 2007 to improve discharge arrangements from acute inpatient services: A Positive Outlook: A good practice toolkit to improve discharge from inpatient mental health care. <http://www.nimhe.csip.org.uk/silo/files/apositiveoutlookpdf.pdf>

Service user and carer experience

Star Wards is a service user led initiative to improve positive user engagement. To date there have been 2 publications Star Wards 1 and 2 with over 475 ideas generated by service users to improve service user engagement and recovery. For more information go to: <http://www.starwards.org.uk>



Recommended reading for any organisation planning workforce redesign which is driven by service user and care need is 'Experiences of Mental Health Inpatient Care' edited by M Hardcastle et al (ISPS, 2007) This publication gives great insight into service user, carer and professional viewpoints regarding different aspects of acute inpatient care. Copies can be ordered from:
<http://www.isps.org/FileArchive/80/inpatientbookflyer&orderform.pdf>

Outcomes

CSIP Outcomes website

The CSIP Outcomes Website provides a range of tools that can usefully be used for measuring outcomes, guidance on good practice and a forum for discussion.
<http://www.outcomemeasures.csip.org.uk/>

FACE (The Functional Analysis of Care Environments)

FACE recording and measurement systems provide a comprehensive suite of tools and software to record and monitor outcomes for service users in mental health services.
<http://www.facecode.com/>

Legislation

Mental Health Act (2007) Briefing sheets on key policy areas and implementation training
<http://mhact.csip.org.uk>

Mental Capacity Act (2005)
<http://www.opsi.gov.uk/acts/acts2005/20050009.htm>

MIND legal briefings
<http://www.mind.org.uk/Information/Legal/>

Sources of information

National sources of available data

A wide range of sources are easily available online to assist the process of establishing accurate current and future needs for the population served by the acute care service.

Data on acute inpatient service activity

Information on the use of acute inpatient services can be obtained from the following sources and can also be usefully benchmarked between services:

- Hospital Episode Statistics
<http://www.hesonline.nhs.uk/>
- Adult Mental Health Service Mapping (available for 2007 at:
<http://www.mhcombinedmap.org/>;
available for 2004-06 at:
<http://www.dur.ac.uk/service.mapping/amh/>)
- Mental Health Minimum Data Set (current from 2003-04) <http://www.ic.nhs.uk/>

Information on the regulation and quality of services

Healthcare Commission

The Healthcare Commission review and regulate acute mental health services and provide a wide range of support materials, and ongoing quality monitoring information from national reviews and audits.



- A primary source of useful information is the Healthcare Commission's 2007 review of acute inpatient services. The home page for the review contains information on the assessment framework, scoring guidance, data collection tools, final scores, summary data and national report Pathway to Recovery. For further information go to: <http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandstudies/serviceproviderreviews/improvementreviewmethodology/adultacuteinpatientmentalhealth.cfm>
- At Trust level information is available in relation to service users' views on a wide range of aspects of their care at Healthcare Commission survey of community patients (2007): <http://www.healthcarecommission.org.uk/nationalfindings/surveys/healthcareprofessionals/surveysofnhspatients/mentalhealth.cfm>
- A useful source of ethnic demographic information relating to the national and regional use of inpatient wards is available from the Healthcare Commission's Count me in census (2007) <http://www.healthcarecommission.org.uk/healthcareproviders/nationalfindings/nationalthemeredports/mentalhealth/countmein/2007.cfm>
- Another source of useful information regarding the management of violence can be obtained from the 2007 Healthcare Commission's National Audit of Violence which is carried out by the Royal College of Psychiatrists at: <http://www.rcpsych.ac.uk/pdf/Mod%20%20national%20report%20WA%20only.pdf>

At Trust level qualitative information in relation to the profile and needs of people in contact with services through the 1983 Mental Health Act is available from the Mental Health Act Commission visit data and reports at: <http://www.mhac.org.uk/?q=node/19>

Local population information

The National Statistics website provides a range of socio-demographic census data at (political) ward, PCT and Health Authority levels (amongst others) that can be used to profile the area covered by a service:

- National Statistics Neighbourhood Statistics <http://www.neighbourhood.statistics.gov.uk/dissemination/>

A source for population projections that is utilised in many areas of planning is the Government Actuary's Department website which provides information on projected population and migration over a 75 year period:

- Government Actuary's Department http://www.gad.gov.uk/Demography_Data/

Local sources of existing data

- **Local Delivery Plan (LDP)**
Primary Care Trusts have developed Local Delivery Plans which describe achievements and progress towards key Department of Health targets. These provide considerable information about the context in which services are being developed locally and nationally. A copy of the LDP should be available on your local PCT website.
- **Local Delivery Plan Return (LDPR)**
The LDPR provides an update to the Department of Health of progress of PCTs and NHS Trusts against the Local Delivery Plan and is used for monitoring purposes. It can provide some of the most recent information available to local services and should be available through the PCT mental health commissioner.
- **Healthcare Commission survey of views of staff**
This study highlights many of the key issues facing mental health staff working across all



services is summarised in a report at the website below. These findings can be compared against local data which has been provided to each Trust:

http://www.healthcarecommission.org.uk/_db/_documents/Staff_survey_2006_MHLD_trusts_key_findings_tagged.pdf).

- Current and historical service usage and staffing resources (funded and actual establishments).

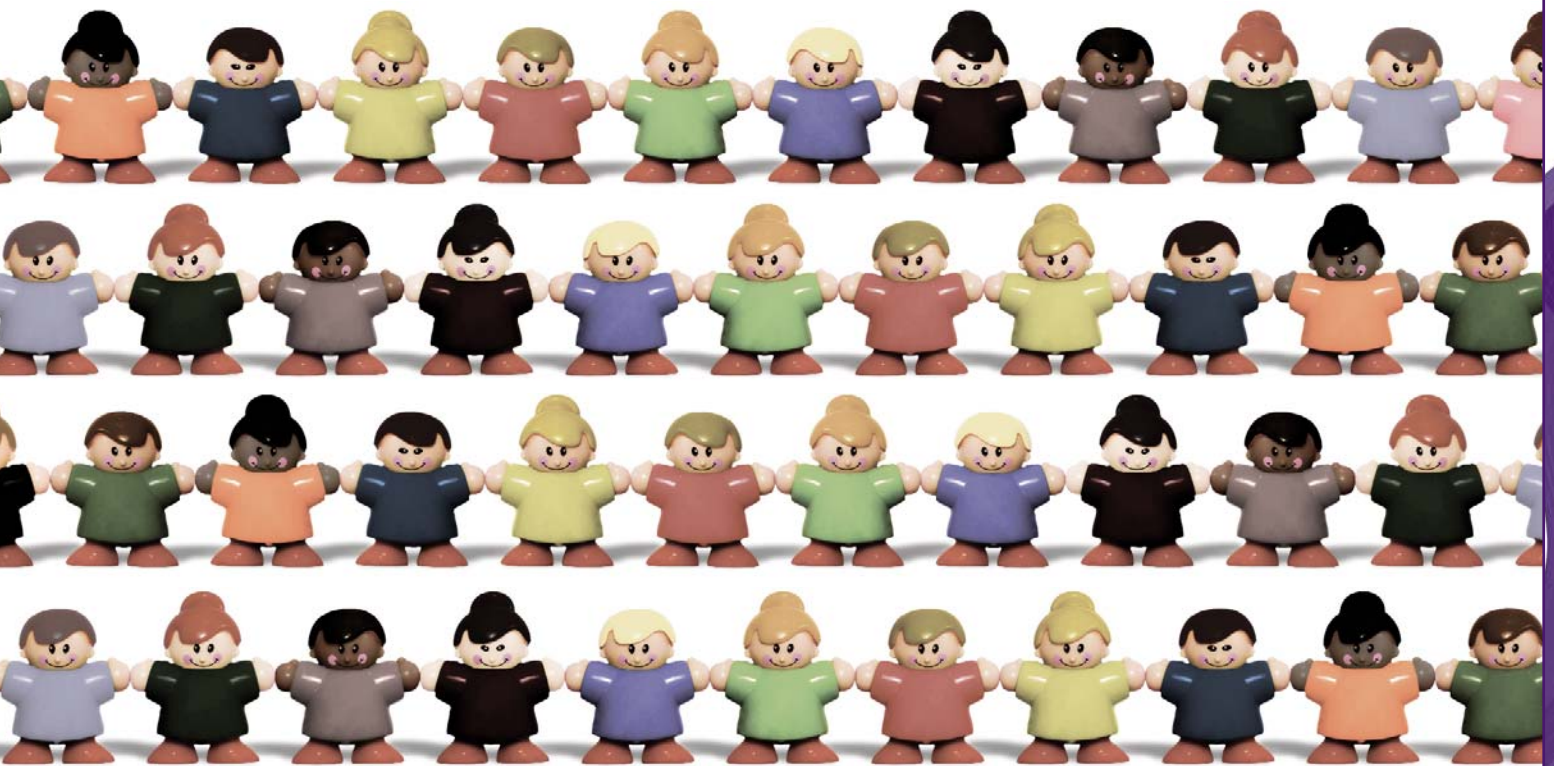
In addition to the data required as part of routine performance monitoring by PCTs and the Department of Health most Trusts will also maintain their own data systems which are likely to provide a rich source of information in relation to past use of services and trends in usage. These can often be usefully interpreted in the context of changes to the service system in order to understand the client profiles at various points in time. Additionally, similar information is often held in relation to the historical staffing resources within the organisation's Human Resources department.

Specifically commissioned supplementary data

A wide range of bespoke data might be gathered specifically for the purposes of workforce planning, for example:

- Staff skills analysis.
- Patient needs analysis (see the Virtual Ward for a range of assessment tools: <http://www.nimhe.csip.org.uk/~virtualward/admission/assessment-tools.html>).
- Caseload audits.
- Root cause analysis of serious untoward incidents.





If you wish to find out more about this document, or want more information, please contact Yvonne Stoddart, Director National Acute Mental Health Project, NIMHE at ylstoddart@yahoo.co.uk

We help to improve services and achieve better outcomes for children and families, adults and older people including those with mental health problems, physical or learning disabilities or people in the criminal justice system. We work with and are funded by

