



**Mental Health Services –
Workforce Design and
Development
Report on the
NIMHE National Workforce
Planning Pilot Programme (WPPP)
Best Practice**

Main Report

National Institute for Mental Health in England
National Workforce Programme

Mental Health Services – Workforce Design and Development Report on the NIMHE National Workforce Planning Pilot Programme (WPPP) Best Practice

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Endorsed by all of the seven WPPP sites:

- Birkenhead and Wallasey and Bebington and West Wirral Primary Care Trusts
- Cambridge and Peterborough Mental Health Partnership NHS Trust
- Dartford, Gravesham and Swanley Primary Care Trust
- Dorset Healthcare NHS Trust and North Dorset Primary Care Trust
- Northamptonshire Healthcare NHS Trust
- Economy-wide Sandwell mental health providers
- Tees and North East Yorkshire NHS Trust

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Introduction

1. The **purpose** of this best practice report is to tell readers about the background to the Workforce Planning Pilot Programme (WPPP); explain the process; provide examples of best practice; and set out the outcomes and lessons learnt from the Programme, to include proposed next steps. This will provide all NHS trusts working with strategic health authorities (SHAs) and other stakeholders, including local authorities (LAs), with a comprehensive, best practice resource to help them take forward local, integrated, joint workforce plans across health and social care.

An integrated, joint workforce plan

2. An integrated, joint workforce plan is a document that sets out a plan for the development of the current and future workforce which is integrated with service development and is agreed jointly between all the relevant stakeholders across health and social care. The components and possible structure of such a plan is clearly set out in this Report.
3. One of the key learning points has been that there needs to be a common understanding of workforce planning across stakeholders. It is not just about the number crunching (important though that is) but it is also about setting the plan into both a national and local context to include the public health agenda. It also includes workforce design (eg introduction on New Ways of Working, New Roles); the education and training agenda; recruitment and retention; looking at sickness and absence; use (and cost) of agency/bank/locum staff; as well as the future workforce and the potential supply combined with the capacity and capability to understand and develop the process.

Background

4. Integrated, joint workforce planning is recognised as an imperative by the statement in the recent White Paper, *Our health, our care, our say*, where it says on pages 185–6: ‘Key to closer integration will be joint service and workforce planning. The NHS and local authorities need to integrate workforce planning into corporate and service planning.’
5. Workforce planning has been an expectation in mental health since the publication of the National Service Framework (NSF) for Mental Health¹ where mention was made about the production of a local workforce strategy to include a review of local workforce issues, an education and training plan, and a retention strategy. At a national level, this was to be supported by what was called ‘National Action – Workforce planning, education and training’, which was taken forward by the Workforce Action Team (WAT) set up by Ministers in 2000.

¹ Department of Health (1999) *Modern Standards and Service Models: Mental Health National Service Framework*, DH, London.

6. Initial and subsequent self-assessments by localities across health and social care showed poor progress was being made. As a result, the Department of Health (DH) assembled a group to look at developing some best practice guidance and this was published in March 2003.²
7. What subsequently became clear was that, while the guidance was warmly welcomed, the local delivery plans (LDPs) showed that workforce planning is not sufficiently robust at trust level (nor is it in other organisations) and localities required help over and above the guidance.

The Workforce Planning Pilot Programme (WPPP)

8. The National Workforce Programme (NWP) of NIMHE decided to develop a WPPP to explore, in practice, what issues needed to be addressed. A central team was set up to drive the project forward, comprising the NWP, the NIMHE/Sainsbury Centre for Mental Health Joint Workforce Support Unit, two workforce development confederations (WDCs), representation from the Durham University database, a NIMHE development centre (DC) and the National Healthcare Workforce Planning Tools Project (membership is at Appendix A). The central team then commissioned each NIMHE DC to put forward no more than two sites each, based on a health and social care locality, to help test and support the development of the planning process set out in best practice guidance and one or more tools to underpin the process, and to consider how the service mapping database hosted by Durham University could feed into workforce planning.
9. The aim was not just to help those particular sites but to disseminate the lessons learnt by way of this Report across the country to SHAs, WDCs (now workforce development directorates (WDDs)), primary care trusts (PCTs), mental health and foundation trusts and LAs, and to provide advice and support by way of the NIMHE DCs.

The pilot sites

10. The central WPPP then chose one site from seven DC regions:
 - Birkenhead and Wallasey and Bebington and West Wirral PCTs;
 - Cambridgeshire and Peterborough Mental Health Partnership NHS Trust;
 - Dartford, Gravesham and Swanley PCT – Kent county-wide project;
 - Dorset Healthcare NHS Trust and North Dorset PCT, as one county-wide project;
 - Northamptonshire Healthcare NHS Trust;
 - economy-wide Sandwell mental health providers;
 - Tees and North East Yorkshire NHS Trust.
11. London was not able to put forward a pilot site for inclusion in the programme.

² DH (2003) *Mental Health Services – Workforce Design and Development: Best Practice Guidance*, DH, London.

12. Background information about each pilot site is contained in Appendix B with contact details.

Launch event

13. A launch event was held on 25 March 2004 with the aim of clarifying:
 - the expectations of the pilot sites;
 - what support the central WPPP team was able to provide;
 - the link to the National Healthcare Workforce Planning Tools Project;
 - use of the Durham University database;
 - providing a forum for a workforce planning network to come together.
14. The event also heard about:
 - the importance of local stakeholder engagement;
 - the need to build capacity to undertake workforce planning;
 - the need to have effective engagement with the LDP process;
 - the need to develop a project plan as part of the process in putting a local workforce plan together across all the appropriate agencies.

Follow-up with the pilot sites

15. A series of some 40 visits, consultation meetings and teleconferences have been made by members of the central WPPP team to all the seven sites. The aim was to:
 - engage with the local project teams and stakeholders;
 - see how far they have come;
 - establish what help they need;
 - provide guidance and support;
 - facilitate good networking;
 - disseminate emerging practice;
 - comment on local draft action/project and workforce plans;
 - be clear about their perceived progress.

The meetings have proved very useful to all parties and are leading to the development of project plans setting out the steps that need to be taken to develop a fully worked up local, integrated, joint workforce plan.

The second national event

16. A second event took place on 10 September 2004 to hear about the progress each pilot site was making, the lessons being learnt and what good practice was emerging (appropriate extracts are included in the **Lessons learnt** section of this Report). The event also provided a forum for networking. (A copy of the full report of the event is available from John Allcock, Associate Director of the NWP at john.allcock@dh.gsi.gov.uk.)

The third national event

17. A third event took place on 11 April 2005 where the primary aim was to discuss a number of specific issues in some depth which were raised by the sites themselves. Details are contained in Appendix C. (A copy of the full report of the event is available from John Allcock, Associate Director of the NWP at john.allcock@dh.gsi.gov.uk.)

Ongoing support and further guidance

18. As part of the ongoing support to the seven sites, the WPPP has produced:
 - a note about recruitment, retention and returners (July 2004) – see Appendix D;
 - a note setting out the levels of responsibility for workforce planning at each level of the process, eg service managers, local implementation team (LIT), trusts etc (November 2004) – see Appendix E;
 - finally, an outline joint workforce plan (January 2005) – see Appendix F.
19. All these pieces of guidance have been circulated to all the NIMHE DC workforce leads as well as the mental health leads in SHAs.

Lessons learnt

20. The following internal and external lessons have been learnt from the pilot sites:
21. **GUIDANCE:** The best practice guidance provides a very good model and process to follow.
22. **COMMITMENT, VISION AND OWNERSHIP** at all levels. This needs to come from the top whereby the chief executive(s) and the trust board recognise the crucial importance of workforce planning.

Best practice: At an early stage, those responsible for taking forward the development of the local, integrated, joint workforce plan, should make a presentation to the trust board or economy-wide mental health partnership boards setting out the aims of the programme, the proposed methodology, the milestones, the intended outcomes, the resources required and that workforce planning should be integral to the overall business planning process. They should also offer to keep the board informed by way of regular reports/updates, either orally or in writing. There should be a board-level director who will sponsor and support the project, who may also ensure accountability for deliverables and outcomes. (Tees and Sandwell)

23. The intention here is to signal the importance of the work and to gain the commitment of the board to include making the appropriate financial and human resources available. In addition, such a process will provide an opportunity, should the need arise, for the workforce planning lead (or group) to say to the board: “We cannot make progress on X and we need your assistance to help us work through this problem.”

24. **LOCAL LEADERSHIP** to drive the project forward and hold it together. Such leadership is required by each of the relevant stakeholders or partners – for example to persuade or cajole their own organisations to participate and provide information/data, etc – but within that structure there needs to be a single, overall leader who holds the whole development programme together.

Best practice: The Dorset county-wide and Sandwell economy-wide projects have leaders for each of the five individual partners (eg the NHS trust, the PCT, the county council, the borough council, and the local council) but the human resources (HR) manager in the NHS trust has successfully taken the overall leadership role.

25. **SUSTAINED EFFORT AND DETERMINATION** to getting the job done. It can be a a long and sometimes difficult process, with many obstacles and pitfalls along the way. Without determination to see it through and to sustain the project, which may take more than a year to complete, it would be quite easy to say it is too difficult. Vital opportunities would then be lost (eg a chance for agencies to work together for the common good), and it will only be storing up trouble for staff recruitment and the delivery of services later on.
26. **CAPACITY AND CAPABILITY:** The need for dedicated, skilled resources to provide the capacity to undertake the work and provide organisational commitment, usually by way of a specific workforce project manager/planning officer, is vital. For example, a person with the capacity and capability should be designated to provide support and/or co-ordinate the workforce planning process. Financial support for such posts often comes from a mixture of sources, including the trust, the SHA and the NIMHE DC.

Best practice: Appendix G provides some example job descriptions. There is no ‘ranking’ or prioritising of the examples. **Example one** provides a support function for the workforce planning process. **Example two** provides not just a support function but also a more proactive role by way of a liaison function. **Example three** provides for a more strategic role in that it involves the co-ordination of a workforce development strategy working across a wider range of organisations and interests. **Example four** has a support and facilitation role. All of these roles require good organisational and communication skills.

27. Appendix K contains details of the Workforce Planning Competence Framework developed by Skills for Health and the NHS National Workforce Projects. The Framework provides a suite of competences that are necessary to carry out workforce planning to enable the delivery of safe and effective care to patients and the public.
28. **EFFECTIVE INTERNAL PARTNERSHIP:** Within the lead trust, the ability to build up and sustain good links and working relationships between those responsible for service planning and delivery, HR, service managers working closely with staff, and finance, all working to the same agenda, goals and timescales, is vital. The seniority of the post is important here. (With regard to a ‘lead trust’, the suggestion is that as the biggest and perhaps most complex organisation, a trust should lead the workforce planning process and have this function as part of its infrastructure. In such a way, it should be best placed to be the anchor to support an integrated, local, joint approach.)

29. **EFFECTIVE ENGAGEMENT OF FRONT-LINE MANAGERS AND STAFF:** Within each provider organisation, it is important that front-line managers and staff have a role in developing the service model and specifying the workforce required. This engagement serves to increase the staff's ownership and understanding of the workforce planning process.

Best practice: Appendix H provides an example of how Tees and North East Yorkshire NHS Trust consulted with their general managers and service heads to identify the issues as part of the process of developing a workforce plan.

30. **EFFECTIVE EXTERNAL PARTNERSHIP:** This takes time and effort, but if a local, integrated, joint workforce plan is to become a reality, it is vital to work with and across all stakeholders spanning health, social care and the voluntary and independent sectors, which all need to understand 'what's in it for them'. The bottom line is perhaps a recognition that NHS trusts, LAs, etc are all competing for staff in the same market, and working together would benefit all.

Best practice: Five sites in particular are to be congratulated for the way they have developed effective partnership working with all their local stakeholders:

- Birkenhead and Wallasey and Bebington and West Wirral PCTs;
- Dorset Healthcare NHS Trust and North Dorset PCT, as one county-wide project (across five partner organisations);
- Tees and North East Yorkshire NHS Trust;
- Sandwell Mental Health NHS and Social Care Trust economy-wide stakeholders;
- Cambridge and Peterborough Mental Health Partnership Trust.

31. **STRONG LINKS WITH SOCIAL CARE ORGANISATIONS** in both the statutory and non-statutory sectors to include the voluntary, independent and private sectors (ie taking a 'whole systems' approach). (See Appendix C, which deals with how to engage the independent and voluntary sectors.)

Best practice: Sandwell Mental Health and Social Care Trust has effectively engaged with all economy stakeholders to map the whole economy workforce, including the health and social care, voluntary and independent sectors. They then agreed a joint economy-wide workforce strategy and action plan and are now developing a joint learning and development strategy and action plan. This has been managed through the LIT, and a quarterly joint implementation team has been created to develop an integrated mental health service delivery model including adult, older people (OP), drug and alcohol, Child and Adolescent Mental Health Services (CAMHS) and learning disability (LD).

Best practice: Birkenhead and Wallasey and Bebington and West Wirral PCTs sent out a workforce survey to all their local independent and voluntary sector providers, and the response, from about half of them, has allowed the PCT to undertake a very useful (if incomplete) analysis about the key workforce issues affecting those sectors and what it means for the statutory sector.

32. **A GOOD UNDERSTANDING OF EXISTING AND EMERGING POLICY DRIVERS** (for example, the NSF for Mental Health, the NSF for Mental Health – Five Years On report, the NSF Policy Implementation Guide, *Choosing Health: Making healthy choices easier* and *Our health, our care, our say*). These will directly influence both existing and future models of service delivery as part of the local strategic service plan which forms the basis of any local, integrated, joint workforce plan.

Best practice: In the Wirral, the PCT is working closely with public health colleagues to ensure that:

- the workforce plan is founded on population need and evidence-based interventions (including health promotion and prevention) in modernised and innovative health and social care services;
- the plan reflects the Choosing Health agenda, with links to initiatives such as Anti-Stigma and Discrimination and Pathways to Work;
- by taking a wider and integrated view, it helps the plan to be dynamic and sufficiently comprehensive to dovetail with work in CAMHS and Older People's Mental Health (OPMH) services.

33. **LINKS TO THE LITs:** It is important to communicate and engage effectively with LITs, as they are pivotal to the development of mental health services across health and social care and have all the obvious links to the workforce requirements for the future.

Best practice: Tees and North East Yorkshire NHS Trust decided to pilot the project in the first instance directly through two LITs. These were chosen because they had integrated services with health and social care and so met the pilot's overall holistic view of workforce planning. The two LITs were then consulted on the pilot, and the two LIT leads became the partners of the project. Ongoing updates have been given to the LITs, and the local workforce plan is now fully embedded within them.

Best practice: In the Wirral, the Workforce Strategy Group acts as a sub-group of the trust's LIT. The Lead Implementation Officer/Joint Commissioning Manager chairs the Workforce Strategy Group and regularly reports directly to the LIT, as well as to the SHA via the Workforce Advisory Group, on the progress of the project.

34. **METHODOLOGY:** Experience has shown that there is no single methodology that can be used to develop a local, integrated, joint workforce plan. However, the basic premise of involving all the relevant stakeholders (see below) in some form of steering or project group that first of all

develops and monitors an action/project plan which, in turn, underpins the production of a local, integrated, joint workforce plan has been found to be a sound way of proceeding.

Best practice: Appendix J provides two examples of local action plans. The first one, from Tees and North East Yorkshire NHS Trust, is very detailed and follows each of the steps set out in the Workforce Design and Development Best Practice Guidance. The second one, from Dorset Healthcare NHS Trust and North Dorset PCT, is a more strategic plan.

35. The clear message that has emerged is that it takes time to develop and produce a local, integrated, joint workforce plan – longer than one might think. It also takes a great deal of effort and commitment. (For example, the WPPP started in October 2003 and only three of the pilot sites produced a workforce plan by October 2005.)
36. **THE PLAN:** Developing a local, integrated, joint workforce plan will be an evolving process, and localities should not strive to get it either fully complete or fully comprehensive at the first attempt. A ‘bite-size chunks’ approach should be adopted, so it is perfectly acceptable to have a plan that may have some gaps or elements that need further work and development. These should be acknowledged in the plan and, where possible, noted with the names of those responsible for taking work forward with indicative timescales. It is important to make a start and to take things in stages if necessary, building on experience and improving liaison and information. This should be based on a clear action plan. See Appendix J for example.
37. **STAKEHOLDERS:** If a local, integrated, joint workforce plan is to be truly a joint one across all stakeholders, both the NHS and social care side of mental health care, including the voluntary, private and independent sectors, must be fully included in the workforce planning agenda. A need for **effective representatives** who are fully engaged and supported by their parent organisation to help deliver such a plan is vital. The aim is to ensure they are represented on the workforce planning teams and that action is taken to capture robust staff data from these sectors. And, in due course, prison health care and other appropriate organisations within the criminal justice system might also be brought on board. However, it needs to be recognised that the process becomes more complex as the number of organisations (and types of service) involved increases.
38. **SERVICE USERS AND CARERS:** It is important to ensure there is effective and meaningful representation by, and access to, the views of service users and carers, who need to be supported and fully briefed. (For example, meetings and papers should be free of jargon, and service users and carers may require separate briefings before and after meetings.) They want to be consulted at an early stage on new workforce themes such as the Career Framework and the introduction of New Roles so that they can help influence their development.

Best practice: Tees and North East Yorkshire NHS Trust has established a group called ‘Contributing to the Workforce’. It was set up with local service users and carers so that they could see for themselves how they would like to contribute to workforce planning. The inaugural meeting agreed a two-part agenda of (a) hearing about future workforce developments so users and carers could discuss these; and (b) the specific skills they had identified as needing development so that they could enhance their role within the group. The group is now fully established and meets quarterly.

Best practice: Sandwell Mental Health NHS and Social Care Trust has developed a service user group made up of 60 representatives who have supported the review and development of a new mental health service model and have been included in the WPPP.

39. **INVOLVEMENT OF EDUCATION AND TRAINING (E&T) PROVIDERS:** It is important that E&T providers at all levels are involved in the development of a workforce plan from the outset and are not brought in at the end of the process just because a change in E&T needs to come about to support the plan. They can feel quite disconnected from health and social care workforce planning so they need to be linked in at the early stages if changes are to be introduced effectively in accordance both with any strategic service and with local, integrated, joint workforce plans.

Best practice: Tees and North East Yorkshire NHS Trust took the lead by approaching their WDD and the local university as they needed the curriculum/commissioning to change. In one year, some very detailed work took place to:

- undertake an audit/usage of the current E&T portfolio;
- determine the future E&T needs in support of the training plan set out in the workforce plan;
- feed back changes required by the trust, including plans for new modules, discarding old modules that were no longer used and updating existing modules.

The information that led to this work came from evidence from the workforce plan. In addition, the Trust asked for different ways of working, for example more study in the workplace and the provision of self-help workbooks. Assignments will also be chosen by the Trust, such as a dissertation study that centres on a current workplace issue.

The workforce planning task could be enhanced locally by fostering opportunities to engage with E&T agencies. The exchange of information and intelligence and consideration of emerging workforce needs are key to ensuring the Trust moves away from a reactive model to an approach to planning for the health and social care workforce which makes best use of resources.

40. **FUNDING TO SUPPORT THE WORKFORCE PLANNING FUNCTION:** While the function of workforce planning is core to the business of any health and social care provider, it is not always recognised, nor is it supported by dedicated funding. It is unrealistic to expect busy HR (or other) staff to undertake this role as an ‘add-on’ function. ***The WPPP has clearly demonstrated that sites that have put in dedicated resources are the ones that have made the most progress.*** It is likely that effective workforce planning will be vital work for foundation trusts to undertake.

Best practice: The HR department of the Tees and North East Yorkshire NHS Trust appointed a permanent assistant head of HR to deliver on workforce development in 2003, supported by a fixed-term workforce development facilitator. This was a new function and gave rise to increased capacity for all departments to begin to produce robust workforce plans.

41. **MAINSTREAMING WORKFORCE PLANNING:** If the work of the pilot site is to be sustained in the future, and not just taken forward by a small team of dedicated enthusiasts who will inevitably move on, it is essential to mainstream workforce planning into the culture, process and timescales of the trust. This can be achieved by linking workforce planning more closely with the LDP process, plans and timescales; the PCT/LA workforce plans; and the WDD commissioning process. (See also Appendix C.)

Best practice: Tees and North East Yorkshire NHS Trust has been working closely with its WDD, whose Chief Executive said: “The essential element is that organisations would be required, as part of the LDP process, to produce workforce plans by March 2005. Financial support would be given **only to initiatives described in the workforce plans**, thus forcing the link between workforce planning and education commissioning and organisational buy-in to ensure the production of better quality workforce plans.”

Also, in order for Tees and North East Yorkshire NHS Trust to have the linkages with the LDP, the Trust worked jointly with colleagues in planning who were organising the timetable for the LDP and business plan production and ‘piggy backed’ onto this same timetable. It was also led by the Director of Corporate Services, who briefed all managers that workforce plans were now integral to the LDP process. A major piece of learning is that people must have **ownership** of the plan (it should not be done by one department behind closed doors), and this can only be achieved if people see its relevance and linkages.

42. **STRATEGIC SERVICE PLAN:** It is essential to have a clear strategic service plan to provide the foundation for the development of a local, integrated, joint workforce plan for the immediate, medium and long term. See also Appendix C.

Best practice: Tees and North East Yorkshire NHS Trust has also developed a matrix to show how workforce developments fit into the service modernisation delivery model. A copy is available from Judith Hurst at judith.hurst@tney.northy.nhs.uk

43. **ROBUST WORKFORCE DATA:** The experience from the WPPP sites is that the collection of and access to robust workforce data is a complex process that takes a great deal of time and effort, particularly when several different organisations and computer systems are involved. There is a necessity for a workforce tool/database that captures all workforce data from all the different stakeholder organisations’ individual systems and provides a consistent framework and dataset for analysis and maintenance. It is also important to recognise that there are a number of separate stages that need to be understood in taking forward this element of a workforce plan. These are set out in Appendix I along with the lessons learnt, to include additional guidance and advice.

44. **SUPPORT FROM SHAs/WDDs:** The SHA workforce leads have a responsibility to help organisations to develop a local, integrated, joint workforce plan that clearly reflects and articulates the workforce challenges within an organisation and that includes the E&T requirements. As part of this, the provision of support from WDDs should be clarified, as they can take a more corporate view working across the whole sector and patch to include:
- linking with the Government Offices for the Regions to ensure that demographic, public health, environmental, and social inclusion perspectives are reflected in the provision of mental health and social care services;
 - looking at demographic, socio-economic, and education issues, which might also include housing/employment/transport links/ethnicity, etc);
 - looking at potential supply issues;
 - other data analysis, such as comparison of trend data from the 10-yearly census returns;
 - links to the local Chambers of Commerce to help map the potential employment policies and opportunities being provided by the ‘opposition’;
 - links to the Learning and Skills Council at a regional level to help ascertain future funding opportunities and priorities for E&T.

Best practice: Use of public health information. By looking at the substantial increase in the local black and minority ethnic (BME) population between the 1991 and 2001 census in both absolute and percentage terms, it became clear to Northamptonshire Healthcare NHS Trust that the priority for its future recruitment strategy needs to be focused on the BME population, reflecting the potential future supply of their workforce. Cambridge has made extensive use of the public health website to help with the demographic profiles of its localities.

Best practice: The Sandwell economy-wide project developed a local workforce database to capture all the workforce of the 74 mental health providers in Sandwell to inform the service planning process. Work is now progressing to use the national electronic staff record (ESR) database to feed this from all the organisations, except the voluntary and independent sectors, which will continue to provide data from their own systems. This enables the production of a robust workforce information database and offers existing resources from which to benchmark and service plan future needs.

Best practice: Dorset and Somerset SHA has provided invaluable support to the Dorset pilot because it offers an overall view of the whole health economy, including not only the numbers, types, ages, etc of the workforce in healthcare but also a broad and comprehensive analysis of the demographics of the local population. Together, these highlight the potential issues surrounding workforce planning for the future.

45. **PERFORMANCE MANAGEMENT**

Best practice: It was found from Tees and North East Yorkshire NHS Trust that it was essential to embed the workforce plans into a robust performance measurement arena. This was done in two ways. Firstly, two workforce modernisation steering and project groups were established monthly with key senior Trust management on the membership. These groups became accountable to the Board. Secondly, all localities looked at their individual workforce plans and produced performance indicators that could be measured. These were then placed onto the Trust's balanced scorecard and became part of its quarterly performance reviewing system.

Materials to support workforce planning

46. During the lifetime of this work, the central WPPP team learnt about a number of useful initiatives that should help with the workforce planning process. These are set out in Appendix K. There may well be more examples and these can be added to the list as necessary.

Summary

47. Some of the early messages that were emerging from the WPPP were disseminated by way of the NWP newsletter, *Workforce* (No. 5) in November 2004. Copies of this and other newsletters can be obtained from john.allcock@dh.gsi.gov.uk.
48. However, this Report comprises a full summary of the background to the programme, the programme itself, examples of best practice, the outcomes and key learning, and the expectations and proposed next steps for the future.
49. All of the seven WPPP sites are to be congratulated for their hard work and determination in working towards the production of a robust local, integrated, joint workforce plan. Some have made better progress than others, but there are lessons to be learnt across the board from all of the sites.
50. At the date of publication of this Report, one site has produced an economy-wide mental health workforce strategy across health and social care (Sandwell); two sites have actually produced a local, integrated, joint workforce plan (Tees and Dorset); two others have produced one in as yet incomplete draft form (Birkenhead and Cambridge); and one has a target date of spring 2006 (Northants). Sandwell is also now on target to produce an economy-wide learning and development strategy and plan by April 2006, supported by the voluntary and independent sector, piloting the Ten Essential Shared Capabilities (ESC) Framework. It is a measure of how complex and time-consuming the process can be, as the WPPP process started in October 2003. The local, integrated, joint workforce plans/strategy already completed are available from:
- Tees: judith.hurst@tney.northy.nhs.uk (joint workforce plan);
 - Dorset: caroline.wayment@dorsethc-tr.swest.nhs.uk (joint workforce plan);

- Poole: bob.allam@poole.gov.uk (Borough of Poole social care workforce plan);
 - Sandwell: yvonne.warner@smhsct.nhs.uk (mental health workforce strategy).
51. The other sites have not made as much progress, often due to personnel changes and discontinuity in taking the work forward, but they are working hard to put together a local partnership framework that will provide the infrastructure to develop a robust local, integrated, joint workforce plan in due course.
52. As the best practice guidance acknowledged, the client group covered by the guidance (and the subsequent WPPP) was adult mental health, but the methodology it set out could apply equally to CAMHS or OPMH. All of the seven pilot sites recognise this and their intention is to consider CAMHS and OPMH once they are further down the road in both developing and implementing their workforce plans. Tees and North East Yorkshire NHS Trust is already doing this, as well as including LD services. Sandwell is now working with the national CAMHS workforce lead on the rolling out of their programme of work and is currently workforce mapping all children's services in support of its children's trust development.
53. Equally, the best practice guidance methodology and the lessons learnt are relevant to other care groups included in the remit of the Care Services Improvement Partnership, such as OP, children, people with learning disabilities and people with physical disabilities.

Keeping up to date

54. The world, of course, does not stand still and this applies equally to both the NHS and social care field. What the WPPP has come to learn is that it is important to recognise that the development and publication of a local, integrated, joint workforce plan is, and cannot be, 'cast in tablets of stone'. It must be a living document that needs to be modified and updated on a regular basis to take account of the changing environment locally, regionally and nationally. A clear example of this is the draft framework of a joint workforce plan, produced by the NIMHE NWP in January 2005 (see Appendix F), which gave numerous examples of the national policy context at that time. Even though the draft did not set out to provide an exhaustive list, numerous other initiatives, publications, guidance, etc has come into play since that time. To name but a few, in no particular order of importance, these include:
- a workforce response to local delivery plans;³
 - a national framework to support local workforce strategy development;⁴
 - the NHS Integrated Service Improvement Programme and Benefit Realisation Programmes (www.isip.nhs.uk);
 - the Ten High Impact Changes for Mental Health and Human Resource (www.dh.gov.uk);
 - the introduction of the Foundation Trust Programme.

³ DH (2005) *A workforce response to local delivery plans: A challenge for NHS Boards*, DH, London.

⁴ DH (2005) *A national framework to support local workforce strategy development: A guide for HR directors in the NHS and social care*, DH, London.

Next steps

55. The central WPPP team will continue to provide support for those sites in the Programme that have not so far produced a local, integrated, joint workforce plan. In addition, other non-pilot localities have expressed an interest in working towards the production of a workforce plan. The next steps are:
- for the NIMHE DCs to work with WDDs to disseminate the results and key learning of the WPPP more widely across all their regional stakeholders;
 - for the NIMHE NWP to include a workshop on workforce planning as part of the proposed NIMHE NWP ‘Workforce’ conference in 2006;
 - for the NIMHE NWP to support dissemination of the key messages at a strategic level by working collaboratively with the DH Workforce Capacity Branch, the Healthcare Commission, the national Mental Health Partnership Group of Mental Health Trust Chief Executives, the NHS National Workforce Projects, the Workforce Review Team, Skills for Health and Skills for Care;
 - to share learning with other localities that are developing integrated, joint workforce plans, perhaps by way of a dedicated website.
56. Any comments or queries related to this Report should be sent to john.allcock@dh.gsi.gov.uk or, if more local in nature, direct to the appropriate pilot sites.

National Workforce Programme
NIMHE
May 2006

Appendix A – The central Workforce Planning Pilot Programme team

Roslyn Hope	Director, NIMHE National Workforce Programme (Chair) roslyn.hope@nimhe.wmids.nhs.uk
John Allcock	Associate Director, NIMHE National Workforce Programme john.allcock@dh.gsi.gov.uk
Ian Baguley	Trent Workforce Development Confederation (and latterly the Centre for Clinical Academic Workforce Innovation) ibaguley@lincoln.ac.uk
Gyles Glover	Durham University gyles.glover@durham.ac.uk
Tony Lavender	Salomons, Canterbury Christ Church University t.lavender@salomons.org.uk
Malcolm Philip	NIMHE/Sainsbury Centre for Mental Health Joint Workforce Support Unit malcolm.philip@scmh.org.uk
Kate Schneider	NIMHE South West Development Centre kate.schneider@nimhesw.nhs.uk
Karen Scott	Leicestershire, Northamptonshire and Rutland Workforce Development Confederation karen.scott@lnrwdc.nhs.uk
Mike Wren	National Healthcare Workforce Planning Tools Project michael.wren@dh.gsi.gov.uk

Appendix B – Background information about each pilot site

Birkenhead and Wallasey and Bebington and West Wirral Primary Care Trusts, Wirral

1. This is a project covering two primary care trusts (PCTs) where the PCTs are both commissioners and providers of mental health services for people of working age covering the whole of the geographical area of Wirral.
2. The pilot is overseen by a Workforce Strategy Group which covers the Wirral area and whose membership includes:
 - Birkenhead and Wallasey PCT;
 - Bebington and West Wirral PCT;
 - Cheshire and Wirral Partnership NHS Trust;
 - Wirral Metropolitan Borough Council, including Social Services;
 - Cheshire and Merseyside Workforce Development Confederation (WDC);
 - Advocacy in Wirral;
 - Wirral Mind;
 - two service users;
 - representation from public health;
 - representation from NIMHE North West;
 - representation from Wirral Employers' Forum;
 - representation from the independent sector is being sought.
3. The pilot is only covering mental health services for people of working age but is looking to cover Older People's Mental Health (OPMH) and Child and Adolescent Mental Health Services (CAMHS) in due course.
4. The NIMHE North West Development Centre (DC) has provided £10,000 to support the appointment of a part-time project manager with Birkenhead and Wallasey PCT. The project manager has a coordination and liaison function in respect of the work of the project.

Contact: Debbie Mayor, Joint Mental Health Commissioner, deborah.mayor@bkwpcnhs.uk

Cambridge and Peterborough Mental Health Partnership NHS Trust

1. This pilot is based on a specialist mental health trust. The Trust is an integrated mental health provider for people of working age, forensic, OPMH, substance misuse services, CAMHS and some specialist LD services, which covers the whole of the county of Cambridge including Peterborough. The Trust employs some 1,800 staff (whole-time equivalent – WTE) across four main localities (Cambridge, Huntingdonshire, Peterborough and the Fenland), provides services to a population of around 800,000 people and has some £85 million of revenue per annum.

2. The local project team consists of:
 - Cambridge and Peterborough Mental Health Partnership NHS Trust;
 - Cambridgeshire County Council;
 - Cambridge City PCT;
 - Peterborough City Council;
 - Cambridgeshire Learning Disability Partnership;
 - the Norfolk, Suffolk and Cambridge WDD;
 - local MIND projects;
 - Anglia Support Partnership;
 - the Richmond Fellowship.
3. The NIMHE Eastern DC has also attended meetings with the central WPPP team.
4. The pilot is only covering mental health services for people of working age but is looking to cover OPMH and CAMHS in due course.
5. Funding for a project manager was provided by the Trust, the WDC and NIMHE Eastern DC.

Contact: Tim Bryson, Acting Chief Executive, tim.bryson@cambsmh.nhs.uk

Dartford, Gravesham and Swanley Primary Care Trust

1. This is a county-wide project across East and West Kent, coordinated by a single PCT that commissions and provides mental health services.
2. Although the pilot is coordinated by one PCT, workforce planning across the Kent and Medway economy covers two LAs, nine PCTs and two specialist mental health trusts, all of which are culturally very different. One of the greatest challenges facing mental health services is the predicted growth in the Kent population of some 1.7 million by 2016, of which 100,000 will be located in the North Kent corridor. Currently, the NHS and social services mental health workforce for Kent is some 1,400 (WTE) serving a population of around 1.6 million people.
3. The local project team consists of:
 - Dartford, Gravesham and Swanley PCT;
 - East and West Kent LITs;
 - East Kent and Social Care NHS Trust;
 - West Kent and Social Care NHS Trust – an Agenda for Change pilot site;
 - Kent Social Services;
 - Medway Social Services;
 - MIND and RETHINK;
 - Kent and Medway SHA.

4. The NIMHE South East DC has also attended meetings with the central WPPP team.
5. The pilot is only covering mental health services for people of working age but is looking to cover OPMH (but not CAMHS) in due course.
6. Funding for a project manager is available from the SHA but a suitable candidate has yet to be appointed.

Contact: Jo Barnes, Assistant Director, Capacity and Workforce, Kent and Medway SHA, jbarnes@nhs.net

Dorset Healthcare NHS Trust and North Dorset Primary Care Trust

1. This is a county-wide project led primarily by Dorset Healthcare NHS Trust.
2. Dorset Healthcare NHS Trust is a provider of mental health services for people of all ages, for over 700,000 people living in Bournemouth, Poole, Christchurch, East Dorset, Purbeck and surrounding areas. It also provides LD services, a community brain injury service for the county as well as specialist county-wide services for forensic care, eating disorders and specialist prison in-reach services. The Trust has an annual income of £60 million and a staff of 1,692 (WTE).
3. North Dorset PCT, which is predominantly a rural PCT, has a budget of some £75 million per annum. In the north of the county, it provides primary and community services including general practice, community hospitals, community nursing, and rehabilitation and therapy services to a population of around 90,000. In addition, in both the north and the south west of the county, it is responsible, as both commissioner and provider of a number of services, including mental health for people of working age and older people, wheelchair services, drug and alcohol services, family planning and youth advisory services, for a population of about 230,000. The Trust has 600 staff (WTE) providing mental health services with an additional 100 staff from Dorset County Council. It is not a formal health and social care trust, rather it has a Service Level Agreement (SLA) with the county council, with each organisation managing its own staff.
4. The project team consists of:
 - Dorset Healthcare NHS Trust and North Dorset PCT;
 - Dorset County Council;
 - Poole Social Services;
 - West Dorset Mental Health Carers Forum;
 - Lantern Trust, Weymouth;
 - Dorset and Somerset WDC;
 - Bournemouth Council;
 - Dorset and Somerset SHA.
5. The pilot is only covering mental health services for people of working age but is looking to cover OPMH and CAMHS in Dorset Healthcare and OPMH in North Dorset PCT in due course.

6. Funding for a full-time project manager on a two-year fixed contract, based in North Dorset PCT, has been provided by the NIMHE South West DC and Dorset County Council.

Contact: Caroline Wayment, HR Manager, caroline.wayment@dorsethc-tr.swest.nhs.uk

Northamptonshire Healthcare NHS Trust

1. The pilot is based on a specialist mental health trust which is an integrated mental health provider for people of working age, OPMH and CAMHS. However, social care staff are seconded to the Trust rather than being directly employed.
2. Although the Trust covers the whole of the county of Northamptonshire and three PCTs, originally, only one part of the Trust was to be included in the WPPP – a discrete area in the north of the Trust called Heartlands, covering nine mental health teams. This would have only covered some 400 staff as well as some 80 seconded staff from social care. However, the pilot has now been extended to cover all of the Trust.
3. The local project team consists of:
 - Northamptonshire Healthcare NHS Trust;
 - Leicestershire, Northamptonshire and Rutland (LNR) WDC;
 - Heartlands PCT;
 - Northamptonshire Social Services;
 - the voluntary sector;
 - a carers group;
 - a service user;
 - the independent sector.
4. Support for the pilot has been provided by LNR WDC.
5. The pilot is only covering mental health services for people of working age but is looking to cover OPMH (but not CAMHS) in due course.

Contact: Joanna Cousins, Associate HR Director, joanna.cousins@nht.northants.nhs.uk

Sandwell Mental Health and Social Care NHS Trust

1. This is a mental health and social care trust project where the Trust is an integrated mental health provider for adults, OPMH, substance misuse services, CAMHS and LD services, which covers the whole of Sandwell.
2. The local project team consists of:
 - Sandwell Mental Health and Social Care NHS Trust;
 - Sandwell Metropolitan Borough Council;
 - three PCTs;
 - Birmingham and Black Country WDC;

- the voluntary and independent sector;
 - the NIMHE DC Workforce Lead.
3. The pilot commenced by covering mental health services for people of working age and is now rolling out as planned to cover OPMH, CAMHS and LD.

Contact: Yvonne Warner, Director of HR and Organisational Development (OD), yvonne.warner@smhsct.nhs.uk and Lisa Hill, Workforce Lead, lisa.hill@os-pct.nhs.uk

Postscript – Best practice: The Sandwell economy won the HR in Primary Care Award at the National Healthcare People Management Association Awards held in London on 15 September 2005 in recognition of their work on ‘Developing the Sandwell mental health workforce of the future to deliver quality future services to the Sandwell population of mental health users and carers’.

Tees and North East Yorkshire NHS Trust

1. This is a mental health trust project where the Trust is an integrated mental health provider for adults, forensic, OP, substance misuse services, CAMHS and some specialist LD services. The Trust has almost 3,000 staff working from more than 45 sites covering some 120 miles from north to south in Tees and North East Yorkshire. It serves a population of some 800,000 across two SHAs, six LAs and six PCTs. It has an annual budget of £73 million.
2. The local project team consists of:
 - Tees and North East Yorkshire NHS Trust;
 - Stockton and Middlesbrough Council;
 - user and carer representatives;
 - Stockton and Middlesbrough LITs;
 - Durham and Tees Valley WDC;
 - colleagues from public health.
3. The Trust has a clear service development plan by way of their Ad>ance project, which provides for a major reconfiguration of mental health services supported by some £8.9 million of capital finance. This is a two to three-year project with older people’s and rehabilitation mental health services being fast tracked for introduction in early 2006. The Ad>ance project provides for a new model of service provision and not just a re-build of existing services.
4. Social work staff are managed by the Trust but remain on the LA payroll.
5. The pilot is only covering mental health services for people of working age but is looking to cover OPMH and CAMHS in due course.
6. Funding for an assistant head of HR and a project manager has been provided by the Trust and the WDC respectively.

Contact: Judith Hurst, Assistant Head of HR, judith.hurst@tney.northy.nhs.uk

Appendix C – The third national event – 11 April 2005

Purpose

- 1.1 The purpose of the third national event was:
- to receive an update on the Workforce Planning Tools Project;
 - to get feedback on the NIMHE Knowledge Community;
 - in small workshop mode, to discuss three issues in some depth:
 - mainstreaming and sustainability of workforce planning;
 - strategic service plans;
 - engaging the independent and voluntary sectors.
- 1.2 In addition, most of the sites produced a summary note showing what progress had been made or how they had overcome problems/constraints and these were shared across all the sites in the WPPP. (Any key messages have been incorporated under the respective pilot sites in Appendix B.)

Workforce Planning Tools Project

- 2.1 Mike Wren gave a summary of the project's aims as follows:
- The Workforce Planning Tools Project was funded for two years under the National Workforce Information and Planning Programme ending on 30 April 2005. The project developed a range of tools, including the workforce information database tool for strategic health authorities, the workforce alignment tool for the national Workforce Review Team, the workforce planning toolkit website, and a range of tools for linking workforce demand and service planning. The aim was to produce a similar tool linking service and workforce planning for mental health to mirror the process set out in the NIMHE *Good practice guide*. While it was not possible to fully develop and pilot this with the NIMHE pilot sites within the timescale of the project, a prototype was produced and demonstrated at a follow-on workshop held on 12 April 2005.
 - The follow-on workshop demonstrated this model and the thinking behind it as well as other tools which were being developed for workforce planning in mental health by the Sainsbury Centre for Mental Health (SCMH). The latter included a skills matrix tool and the national costing tool. The aim of this second workshop was to explain the principles and to seek engagement in the development process for these tools from pilot sites and other trusts. It was successful in this aim and further development is taking place with trusts of all three tools.

The NIMHE Knowledge Community

- 3.1 Kamaldeep Dhillon of the NIMHE/SCMH Joint Workforce Support Unit gave a presentation about the purpose of the Knowledge Community (KC) and how to get access where workforce is but one subject area among many on the KC website.

- 3.2 The purpose of the KC is to give people working in mental health services, as well as users and carers, an online capability:
- to share information about mental health;
 - to provide examples of innovative practice;
 - to provide a facility for discussion groups to be set up which provide a forum for feedback, sharing experiences and problem solving.
- 3.3 The feedback from delegates was generally positive but the feeling was that logging in was not as easy as it might be and that to use the site was time consuming. It required some dedicated time to do this. While these were legitimate points, Kamaldeep reminded delegates that use of the KC was a different and perhaps novel way of working for some that would take a little while to get used to. The time spent making a connection and using the site should be regarded as a legitimate task and the more it was used, the greater the gain for all concerned.
- 3.4 Annex A gives details about how to become a member of the KC.

Mainstreaming and sustainability of workforce planning

- 4.1 This workshop was led by Judith Hurst who is Assistant Head of Human Resources in Tees and North East Yorkshire NHS Trust – see Appendix B.
- 4.2 In giving the background to the Trust, Judith explained that it had established a number of dedicated personnel to drive the pilot forward, including two WTE posts plus some short-term funding, for four months, of a workforce analyst. The HR function was restructured and Trust Board commitment to the project was secured. In addition, two LITs were keen to support the pilot.
- 4.3 Among the most important decisions taken were:
- not to duplicate work;
 - to align the pilot with local needs and vice versa;
 - not to undertake all aspects of the pilot if it was not beneficial to the Trust;
 - to add new concepts to the pilot.
- 4.4.1 In summary, the process undertaken was:
- all areas were to undertake full workforce planning in 2005 but two LITs were to be involved in broader areas, for example to include the independent and voluntary sector providers;
 - the NIMHE best practice guidance proforma requirements was updated to cover the needs from the pilot, local WDD requests and local requirements;
 - a forum of service users, carers and representatives from the independent and voluntary sector was established to support their involvement in workforce development. This group has now met twice and is developing its role;
 - all service areas were to be included, for example working-age adults, older people, CAMHS, LD and forensic;
 - workforce development workshops are currently being run for staff interested in developing their skills.

4.4.2 This resulted in the production of an eclectic six-point model which is available for all teams and services to use to assist their workforce planning. This includes:

- Point 1: A current list of all staff, including qualities such as gender, age, length of service (LOS) and retirement plans.
- Point 2: A review of current team issues, including recruitment and retention issues, model of care, skill mix, shifts, etc.
- Point 3: A full review of current skills and competencies of all staff, using a skills matrix approach.
- Point 4: A plan outlining future training and education requirements.
- Point 5: This is the main focus of the process and covers the new workforce model, including:
 - pathways of care;
 - new model of service/operational policy;
 - New Roles, New Ways of Working;
 - new numbers.
- Point 6: This section covers alignment with broader local and national agendas such as information management and technology (IM&T), Mental Health Bill, national documents, for example NSF, National Occupational Standards (NOS), Ten ESC.

4.5 The key levers to help ensure that future workforce planning will be mainstreamed and sustained are that:

- it has been fully mapped against and into the annual cycle and timescales of the local delivery and Trust business planning process;
- ownership of the Corporate Strategic Commissioning Group has been secured;
- submissions have been made and agreement secured from the:
 - Trust Board;
 - Clinical Governance Committee;
 - Recruitment and Retention Group;
 - the WDD E&T plans.

Strategic service plans

5.1 This workshop was led by Tony Lavender of Salomons who is a member of the central WPPP team – see Appendix A.

Key issues

- Each representative of the pilot projects gave an update of the progress that had been made with the development of a strategic service plan.
- There was considerable variability. Some pilots had a clearly developed strategic plan with identified service components which could be used as a basis for estimating the future workforce, while others had established the values and intent (but little detail), and others had scarcely begun.

Common problems included:

- Trying to establish and identify a coherent group to develop the plan across a wide range of stakeholders/partners.
- Variability in the engagement of PCTs in the mental health agenda.
- Concern that the costs of Agenda for Change (A4C) and the fact that many trusts and SHAs were overspent meant that a number of services were facing (and dealing with) significant contraction rather than development.
- Organisational change – mergers of trusts and PCTs – leading to changes in key staff which made the development of a coherent strategic plan difficult.
- Developing clear, well-grounded strategic plans (with identified service components) was proving difficult in a number of areas, in spite of agreement at a general level.

Positive ways forward:

- One pilot had developed an innovative service plan by tracking the pathway and needs of patients as they went through the service and working out with users what was needed at each stage.
- Representatives from the pilots offered to make their plans available (probably on request) to the other pilots. There was some discussion of putting information on the KC.
- Much energy had been spent getting the right people together to develop the plan and this had been achieved in spite of significant difficulties between key players.
- Some services had survived a round of cutbacks and had still been able to respond with some innovative plans.

The key message was to keep communicating between pilots about these issues.

Engaging the independent and voluntary sectors

- 6.1 This workshop was led by Barbara Edwards and Peter Ashworth of Birkenhead and Wallasey PCT. They introduced the discussion by saying that while some work had been undertaken to connect with these sectors, there remained a lot to do, especially as there are some 70 voluntary sector organisations in the Wirral area. Ideally, some type of forum to encourage liaison and discussion could be a way forward but this required appropriate resources to be set up and maintained. However, this approach would also improve communications generally and provide other spin-off benefits.
- 6.2 One difficulty is that it is not always clear which independent and voluntary sector organisations operate in a particular locality – it may be necessary to ask the LIT for such information or, alternatively, to look in the telephone directory. Other sources of information might be Commission for Social Care Inspection reports or the SANELINE database.
- 6.3 Wirral MIND, one of the biggest mental health voluntary providers in Wirral, has information about its staff, including their age and ethnic breakdown; how long they have been in post; and qualifications and skills held, although a high proportion of these may not be formally accredited.
- 6.4 If the independent and voluntary sector providers are to be engaged effectively, not just to provide workforce data but, more importantly, as part of the development of a local, integrated, joint workforce plan, then they need to be part of the workforce planning group (WPG) in whatever form that takes locally. Their capacity to take part should be considered, for example it may not be possible for them to attend on a particular day as it is their busiest, so scheduling in a meeting of the WPG for that day is counterproductive. In addition, it is no good giving them just a day or two to respond to what may be a lengthy or complicated report full of jargon. So are members of the WPG clear about what support, background information and resources the independent and voluntary sector providers require to make an effective contribution?
- 6.5 A key point for discussion was the capacity of voluntary sector organisations to supply detailed information on their staff, particularly if the organisation works across a number of localities, across different trust boundaries and has a high turnover of staff. This is particularly true if records are kept manually rather than electronically. But capacity is not the only issue as voluntary sector organisations may have policies on confidentiality that prevent them sharing detailed information on staff with anyone outside their organisation. This needs to be discussed and relevant protocols drawn up. One method that might help is to require certain, key information to be provided by the independent or voluntary sector organisation as part of any contract being drawn up around the delivery of services.
- 6.6 Generally speaking, voluntary sector organisations do not have a separate HR function that collates staffing information on a regular and necessarily robust basis. The trust asking for information to help develop a workforce plan should consider carefully what information it needs rather than wants, and precisely what use it will make of the data provided. It may be better to start small with a few key bits of information and build on that slowly over the medium term. Careful construction of any questionnaire is vital so that it not only produces the information required but does so in an easy-to-use format, for example use of tick boxes or 'yes'/'no' alternatives. However, non-completion should be followed up assertively.

- 6.7 In addition, the trust should ask ‘What is there in it for the voluntary sector organisation to participate in such a data-gathering exercise?’ What incentives are on offer? Is the trust going to offer to help pay for, or contribute to, the education and training costs of some or all of the voluntary sector organisation staff, for example?
- 6.8 Use should be made of any existing data collection exercises, for example the new Skills for Care (formerly TOPSS England) Minimum Data Set (MDS) which social care employers, including the independent and voluntary sectors, are going to be encouraged to use.
- 6.9 The final key messages are to keep things simple, undertake one step at a time and to concentrate on only what is absolutely essential.

Annex A – How to become a member of the Knowledge Community (KC)

The WPPP on the KC website

It was always agreed that a group would be set up on the web to support the workforce planning pilots. Various staff members have now been trained at the SCMH on the KC, and groups are being set up. We now need everyone to join the KC so everyone is connected to the online group.

What do you need to do?

1. Join the KC. Go to **<http://kc.nimhe.org.uk>** and request membership, if you have not already done so. In about half an hour you will get an e-mail with a password. Log on and change the password to one you will remember!
 - Requesting membership: Go to **<http://kc.nimhe.org.uk/>** (home page of the KC) and about a third of the page down there is a sentence that ends with ‘**apply here**’. On ‘clicking’ on the ‘apply here’ you will be taken to the application form which is self-explanatory.
 - For more information on how to become a member you could also go to ‘**Help**’ (on the top right of the home page), then choose ‘**getting started – requesting membership**’.
2. Then send an e-mail to Malcolm Philip at malcolm.philip@scmh.org.uk to tell him you have logged on to the site and he will send you an e-mail inviting you to join the NIMHE WPPP group. Note you cannot find the group on your own by searching on the KC: it is a closed group, see 3, and thus can only be seen by group members.
3. The group is a closed group on the website meaning that only group members can find and access the group, and any documents, e-mails, etc go only to group members.
4. **It is also intended to load up copies of documents, plans, etc you have sent through on your project. Please tell Malcolm Philip as soon as possible if there is anything you do not want loaded up for other pilot sites to see.**

Malcolm Philip
NIMHE/SCMH JWSU

Appendix D – A note about recruitment, retention and returners

Workforce planning

Introduction

1. Set out below are a number of examples of innovative practice and tips that local workforce planning teams may wish to consider as part of their workforce planning process. There is no sense of prioritisation or ‘ranking’ in the examples given.

Recruitment

Black and minority ethnic communities

- 2.1 Do you know how many of your staff are from black and minority ethnic (BME) communities? What is their ethnic, age and gender breakdown? Are they spread equally across the trust sites? Are the majority (or all) in junior to middle-ranking posts/grades? Do you need to initiate a potential leadership or senior management programme? Are your BME staff not well represented in any one type of employment? If so, what can be done to encourage recruitment into these jobs? Do you know what the barriers are to recruitment? Do the individual ethnic and total breakdowns represent the make-up of your local communities? What specific action have you taken to ‘target’ the recruitment of staff from BME communities? Are there any local champions who might help you, for example church or community leaders, or schools?

Local housing developments

- 2.2 Do you know what is planned for your local community, town or city and what does this mean for the local morbidity and the need for more staff? For example, one area has become aware of a huge new housing estate to be built consisting of both starter homes and homes for young families, with several thousand new residents coming to live in the locality. This will almost certainly increase the morbidity of post-natal depression so what will the extra pressure be on general practice? What type of extra staff will be needed and by when?

Census data

- 2.3 Do you know what the 2001 census data is telling you about your locality compared to the 1991 data? What shifts in the population have occurred? For example, in London there has been a substantial increase in the BME community. In the Midlands, some of the large cities have had a significant reduction in population numbers.

Children

- 2.4 Did you know that by the age of 9 to 10, most children have already discarded a large proportion of possible employment opportunities? So what action do you propose to engage with schoolchildren regarding possible employment in NHS and social care services? Don't leave all your schools recruitment until the GCSE stage – by then it will be too late for many.

Primary care graduate workers (PCGWs)

- 2.5 How many people applied to become PCGWs? The clear message is that there was considerable over-subscription for these posts but what has happened to those who were not successful? A number of localities we have spoken to did not do anything with the unsuccessful candidates and yet these people have clearly shown an interest in working in mental health services. It seems a waste to simply turn them away. Do you still have their contact details? Why not ask them if they might want to work elsewhere in the trust and perhaps start a different career?

Retention

Local environment

- 3.1.1 When one mental health trust in London undertook a workforce survey, it recognised for the first time that, while it had no specific problem recruiting staff, in one particular locality the retention of staff was poor, especially during the winter months. Basically it had nothing to do with the trust or staff not wanting to work for the NHS, rather it was an environmental problem.
- 3.1.2 In a nutshell, the local area around the hospital site was appalling and it seemed worse during the dark winter months. The immediate area around the hospital exit was poorly lit; there was graffiti on the walls and rubbish was strewn about; the pavements were not maintained properly; some of the local shops and houses were either boarded up or were in a state of disrepair/poor decoration; the buses only ran once an hour after 4.00pm, if at all, and the bus shelters were vandalised. And there were even burnt-out cars in the street. In addition, there seemed to be no security – one never saw a police officer, for example. Female staff felt especially vulnerable and it was no wonder they decided they could not run the risk of being out in that environment late at night or in the dark afternoons or evenings in the winter. This was the major contributor to poor staff retention but none of this was actually the direct responsibility of the NHS. What could be done?
- 3.1.3 The trust's chief executive did a number of things. First, he worked with the local community, shopkeepers and staff/unions to form an action group. After the local community and shopkeepers had set an example by cleaning up their own premises, which improved trade, together they tackled the local authority to get the immediate streets cleared of the rubbish, graffiti and cars removed, the street lighting improved and the pavements repaired. In addition, they lobbied the local bus company not only to make the buses more reliable but also to put on extra buses after 4.00pm so staff would not have to wait too long. And electronic screens were installed in the repaired bus shelters so passengers would know when the next bus was due. Security wise, the local police superintendent was most cooperative and agreed to make the police presence more visible, particularly at times when staff felt most unsafe. And the hospital security staff agreed to walk out of the hospital main exit at varying times and walk down to the main bus shelter, staying for a short while, to give the impression of a secure environment. (There was no suggestion of their being asked to act as some form of vigilante force – it was more a matter of appearance or deterrence.)
- 3.1.4 This combination of measures, together with local support and goodwill where people and organisations were looking for some form of leadership, made the staff appreciate what their employer was doing on their behalf and, with a better and safer environment, the loss of key staff was reduced and this helped to contribute to improved retention in the trust.

Staff age breakdown

- 3.2 How many of your staff are in the 50–55 and 56–60 age brackets? Where are they located in the trust? What types of staff are they? For example, are the majority in nursing? What are their intentions regarding retirement? What might tempt them to stay on full time? What arrangements might you make to retain them as part-time or job-share staff? How would their existing teams cope either without them or under any part-time/job-share arrangements? What are you planning to do now for the forthcoming bulge?

Mental health officer status

- 3.3 Do you know how many of your staff retain mental health officer (MHO) status and so are able to retire early? Who are they? Are they concentrated in one part of your services? Have you asked them what their plans are? What proportion of the total staff do they represent both across the whole of your organisation or in the localities they are working in?

Local authority staff

- 3.3.1 It is often said that, for a variety of reasons, it is very difficult to collect staff data in respect of those who work for the local authority. It is not the aim of this note to say how this might be done, rather it suggests starting small by mapping a key group of staff. These are the approved social workers (ASWs) under the Mental Health Act.
- 3.3.2 Given their key role, it is vital that localities have a handle on their ASW numbers and that they know their intentions should the proposals under the Mental Health Bill come into effect. This is because the current role of the ASW will no longer be the sole preserve of social workers but will be undertaken by approved mental health professionals (AMHPs). They could be social workers but, equally, they could be nurses if they have undertaken the appropriate training. Some ASWs are saying that should the Mental Health Bill become law, they will no longer carry out the ASW role and will simply revert to being ‘ordinary’ social workers. If this were to happen in sufficient numbers, the effect could be quite dramatic and plans to tackle this ‘worst case scenario’ need to be put in place now.
- 3.3.3 Given this possibility, even if the local workforce planning group (WPG) does not currently know details of the wider personal social service – the local authority – staffing data, it is important to start soon with the ASWs. Some of the questions a WPG may wish to consider asking are: How many are there? What areas or teams do they serve? What is their age, gender and ethnic breakdown? What languages do they speak? What skills do they possess and what development needs do they have? How can these be met? How long have they been qualified? What has been the recent trend in terms of qualification, recruitment, retention and retirement? Where does the existing education and training take place? Is it geared up to undertake the education and training of AMHPs? Would any ASWs who have recently left be willing to return on a part-time or job-share basis? What is the current vacancy situation? Where are the vacancies and how long have they been unfilled? What do the current ASWs intend to do should the Mental Health Bill become law?

Sick and absent staff

- 3.4.1 What is the sickness and absence rate of staff in your trust? Is it too high? What is the ‘cost’ of providing cover? Does this affect one type of staff more than any other? Is it higher in any one or more service setting or geographical locality? Does it happen more often at one time in the year, for example when particular sports events occur? What is the trade union view? Have you thought about introducing a system where on return to work, each member of staff is interviewed by their line manager and asked about their time away from work? The aim is to allow managers to be satisfied that the absence was genuine. This process has helped reduce staff absence in some parts of the private sector.

Returns

Keep In Touch scheme

- 4.1 Does the trust have a KIT (Keep In Touch) policy and process whereby when staff leave, the trust keeps in touch with them? It can do this by checking their address at least yearly, sending them the staff newsletters or other publications, having annual ‘job fairs’ to which they are regularly invited, etc.

Summary

5. This is not intended to be an exhaustive list of things to consider but it does give some ideas as ‘a starter for ten’. A key initiative is the ‘Improving Working Lives’ (IWL) programme but that is not just about the NHS. Its principles and sound advice apply equally to the social care sector, both statutory and non-statutory, as well as to the private, independent and voluntary sectors.

NIMHE
Workforce Planning Pilot Programme
July 2004

Appendix E – The levels of responsibility for workforce planning

November 2004

**WORKFORCE DESIGN AND DEVELOPMENT
(MENTAL HEALTH SERVICES FOR PEOPLE OF WORKING AGE)
LEVELS OF RESPONSIBILITY**

Dear Colleague

As you may know, the National Workforce Programme (NWP) of NIMHE has set up a Workforce Planning Pilot Programme to help test and support the Workforce Design and Development Best Practice Guidance⁵ published in March 2003. Outline details of the Programme are contained in the 5th NWP newsletter 'Workforce', copies of which are obtainable from john.allcock@dh.gsi.gov.uk and the Knowledge Community.

One of the developments in the Programme has been the call for a note that sets out the responsibilities for workforce design and development at the various levels in the process over and above what is contained in the Best Practice Guidance.

I attach the latest version of the note which is laid out in the form of a hierarchy and, in bullet point format, describes what the responsibilities are at each stage in the process. This needs to be read in conjunction with the Best Practice Guidance.

The note can be used by each of the stakeholders, as a form of aide memoire to remind them what needs to be done or put in place for the successful implementation and on-going support of a joint Workforce Plan across agencies.

If the process of developing a joint Workforce Plan is to succeed, there are two key things that need to be in place. They are a sense of ownership and commitment to the process by all the stakeholders and the provision of some dedicated resources to undertake and sustain the process.

I hope you find the note helpful and would welcome any feedback. These should be sent to John Allcock.

Yours faithfully

Roslyn Hope
Director
National Workforce Programme

5 DH (2003) *Mental Health Services – Workforce Design and Development: Best Practice Guidance*, DH, London.

Workforce Design and Development (Mental health services for people of working age) Levels of responsibility (4th Draft)

Service/frontline managers

- have a sense of ownership (at the micro level)
- have basic Human Resources competencies (eg potential career development skills and linking staffing profiles to Workforce Design and Development)
- feed intelligence upwards via line management thus feeding into the Local Delivery Plan (LDP) process
- identify current and future hotspots – suggest potential solutions (eg reviewing skill mix)
- identify skills gaps using Ten Essential Shared Capabilities and the Knowledge and Skills Framework/National Occupational Standards

Local Implementation Teams

- have a sense of ownership (at the co-ordinating level)
- identify current and future trends and hotspots
- co-ordinate local intelligence and potential solutions
- feed intelligence through to the LDP process
- co-ordinate and contribute to the development of Strategic Service and Joint Workforce Plans

Primary Care and Mental Health Trusts

- have a sense of ownership (at Board, Chief Executive and the operational level)
- have a sense of commitment to work closely with other agencies/stakeholders
- to provide the necessary dedicated resources to undertake workforce design and development
- collect and analyse staff data on numbers/types/ages/gender/ethnicity to identify past and likely future trends and action required and to include new types of workers in this process
- identify local labour markets and action required
- identify local employment opportunities ie who are their competitors and for what type or level of employment
- identify local housing developments (potential staff recruitment and increasing workload)
- identify local educational developments (eg a new sixth form college)
- identify emerging pressures (eg prison in-reach services, new forensic facilities etc)
- ensure consistent Recruitment, Retention and Returner's approach across the Trust eg between Working Age Adult/Older People/Child and Adolescent Mental Health Services and social services (to prevent poaching, best use of resources)
- link to future education and training requirements and skills developments

- feed through to the LDP process
- feed through to the development of the Local Strategic Partnerships
- develop a clear project plan setting out the steps required to develop a ...
- workforce plan setting out what is to be achieved; by when to include priorities; who is responsible; resources and support required mapped to local needs and national workforce/team targets; and links to other agencies/stakeholders

Local Authorities (LAs)

- have a sense of ownership of the mental health social care workforce
- to link the social care workforce initiatives with the mental health priorities as part of the Local Strategic Partnership
- provide access to staff data (eg numbers, types, ages, ethnicity, gender etc) on social care staff to Trusts

Strategic Health Authorities/Workforce Development Confederations (WDCs)

- have a sense of ownership (at the strategic or regional level)
- work with local health and social care systems to develop Strategic Service and Joint Workforce Plans and monitor these
- identify current and future economic growth across the patch
- to undertake a labour market survey
- identify future supply factors at a strategic or regional level eg infrastructure changes such as new transport links (easier for people to travel into [or out!] of locality)
- identify future business environment eg large companies moving into area
- analysis of census data to map changes between 1991 and 2001
- collate and analyse population, demographic, morbidity and socio-economic data to include deprivation
- help with and co-ordinate international recruitment
- analyse entry into and attrition from education and training
- work with local stakeholders to develop a meaningful, consistent and common set of staffing codes across agencies
- work with education and service providers to improve relevance and quality of education and training

NIMHE Development Centres

- have a sense of ownership (at the Organisational Development level)
- provide facilitation to encourage local ownership and common sense of direction with all stakeholders across the statutory (NHS and LA) and non-statutory (private, voluntary and independent) commissioners and providers of services *which is mental health specific* [WDC work will be across all client groups, not just mental health]

- help with the introduction of new workers into the mental health workforce eg Support, Time and Recovery, Primary Care Graduate Workers, Gateway etc
- help with the introduction of new ways of working for professional staff
- help to identify and share good practice/documentation/process
- facilitate problem solving across the 'region'

Appendix F – An outline joint workforce plan

National Workforce Programme
Osprey House, Albert Street
Redditch, Worcestershire B97 4DE

Tel: 01527 587 623

January 2005

**WORKFORCE DESIGN AND DEVELOPMENT
(MENTAL HEALTH SERVICES FOR PEOPLE OF WORKING AGE)
JOINT WORKFORCE PLAN – DRAFT FRAMEWORK**

Dear Colleagues

As you may know, in November 2004, we produced a Note that set out the Levels of Responsibility for Workforce Design and Development to help people/organisations have a better understanding of the process, over above what was contained in our Best Practice Guidance of March 2003.⁶ If you do not have a copy of this Note, please contact John Allcock, Associate Director of the National Workforce Programme on john.allcock@dh.gsi.gov.uk.

Following on from that Note, we have been asked to produce a framework of a Joint Workforce Plan that provides more information that was contained on page 32 of the Guidance.

This is now attached and whilst it is not intended to be prescriptive either in terms of content or layout, I hope you find it will prove helpful. It is, of course, a draft Framework as it will always be part of an iterative process and not cast in tablets of stone.

You will find the Framework self-explanatory but what we have inserted in shaded form are various notes that provide some background explanation or amplification of the text, particularly where the information being collated should lead to some form of analysis being undertaken.

What we have not included is a section or chapter on the methodology to be used to develop a Joint Workforce Action Plan. Our experience is that there is ‘no one size fits all’ and it is for each locality to decide how best this might be undertaken. Apart from the seven sites included in our national Workforce Planning Pilot Programme, we have details of other localities that have or are developing a Joint Workforce Plan and we would be happy to share details with you.

Although there is a certain amount of ‘plagiarism’ in putting this draft together, taken from some examples of good practice, there is also some original thinking here as well. We know it will need amending over time so any comments, feedback, additions or corrections to the draft Framework would be most welcome and should be sent direct to John Allcock.

Yours faithfully
Roslyn Hope
Director
National Workforce Programme

⁶ DH (2003) *Mental Health Services – Workforce Design and Development: Best Practice Guidance*, DH, London.

Workforce Design and Development (Mental Health Services for People of Working Age) Joint Workforce Plan Draft Framework (Version 3) [References correct as at publication in January 2005]

Executive Summary

- 1.1.1 The key points of the Joint Workforce Plan to include reference to the workforce not being just the NHS but across all relevant stakeholders, professional and other staff.

National Policy Context

- 1.2.1 Brief summary/main points of the national policy context.

Generic workforce publications/guidance

[Potential examples to use/quote, not an exhaustive list – in no particular order of importance.]

- A First Class Service
- Improving Working Lives
- The Human Resources Performance Management Framework
- Modernising Medical Careers – the New Consultant Contract
- Modernising Social Services
- Best Value
- Working Time Directive
- Investors in People
- Agenda for Change
- Funding Learning and Development
- NHS Plan (NHSP)
- Human Resources in the NHS Plan
- The NHS Improvement Plan
- *National Standards, Local Action*
- Public Health White Paper

Mental Health specific publications/guidance

- Modernising Mental Health Services⁷
- National Service Framework (NSF)⁸
- *The Mental Health Policy Implementation Guide*

7 DH (1998) *Modernising Mental Health Services: Safe, sound and supportive*, DH, London.

8 DH (1999) *National Service Framework for Mental Health: Modern standards and service models*, DH, London.

- The Workforce Action Team Final Report⁹
- The Journey to Recovery¹⁰
- Gateway Workers¹¹
- Graduate Primary Care Mental Health Workers¹²
- Organising and Delivering Psychological Therapies¹³
- National Mental Health Workforce Strategy¹⁴
- New Ways of Working Interim Report¹⁵
- Support, Time and Recovery (STR) workers¹⁶
- New Mental Health Bill¹⁷
- The National Occupational Standards for Mental Health¹⁸
- The Ten Essential Shared Capabilities¹⁹
- Community Development Workers for Black and Minority Ethnic Communities²⁰

[Set out the broad aims and how they impact on workforce design and development]

Local Policy Context

- 1.3.1 Describe the impact of the National Policy Context on Local Mental Health services in a mixed economy of care combined with plurality of provision.
- 1.3.2 Number and role of the Local Implementation Team(s) (LITs) [making reference to the capable LIT] and links as part of the Local Strategic Partnership.
- 1.3.3 The local stakeholder perspectives [eg Primary Care Trusts (PCTs); Mental Health Trusts; Local Authorities (LAs); voluntary sector organisations; private sector providers; pharmacy] and what the local drivers are.
- 1.3.4 Detail the locality profiles [eg what is being delivered where and by whom to include broad details of expansion plans].

9 DH (2001) *Mental Health NSF (and the NHS Plan): Workforce planning, education and training – underpinning programme: adult mental health services: Final report by the Workforce Action Team: August 2001*, DH, London.

10 DH (2001) *The journey to recovery – The Government's vision for mental health care*, DH, London.

11 DH (2003) *Fast-forwarding primary care mental health: "Gateway" workers*, DH, London.

12 DH (2003) *Fast-forwarding primary care mental health: Graduate primary care mental health workers, best practice guidance*, DH, London.

13 DH (2004) *Organising and Delivering Psychological Therapies: July 2004*, DH, London.

14 DH (2004) *Mental Health Care Group Workforce Team: National Mental Health Workforce Strategy: August 2004*, DH, London.

15 DH (2004) *Guidance on new ways of working for psychiatrists in a multi-disciplinary and multi-agency context*, DH, London.

16 DH (2003) *Mental health policy implementation guide: Support, Time and Recovery (STR) workers*, DH, London.

17 DH (2004) *Draft Mental Health Bill 2004*, DH, London.

18 NIMHE (2003) *The National Occupational Standards for Mental Health*, NIMHE, London.

19 DH (2004) *The Ten Essential Shared Capabilities – A Framework for the Whole of the Mental Health Workforce*, DH, London.

20 DH (2004) *Mental Health Policy Implementation Guide – Community Development Workers for Black and Minority Ethnic Communities: Interim Guidance*, DH, London.

- 1.3.5 Outline the links with prison health care; other parts of the criminal justice system; primary care etc.
- 1.3.6 Outline the links with Child and Adolescent and Older People Mental Health Services.
- 1.3.7 Description of the local monitoring arrangements in respect of the mental health service and workforce targets.

[Precise details to show progress against the Local Mental Health Workforce Targets in an Annex (A in this draft)]

1.3.8 Details about the:

- geography of the local patch; [to include a map perhaps]
- demographic makeup of the local population such as age/ethnicity/gender including likely changes;
- local transport networks;
- housing;
- other forms of economic development; [eg new industries or urban/rural regeneration]
- educational attainment, number of pupils leaving at ages 16 and 18 and going on to higher education;
- other competitors/employers to include future employment trends/growth.

[All these might show a comparison to national data eg the local ethnic population is growing at a faster rate than the national figure – what does this mean for the future supply of the workforce and recruitment priorities?]

- 1.3.9 Support received or required from the Strategic Health Authority (SHA)/Workforce Development Directorate(s) (WDDs).

[This might include a labour market survey to include a comparison of local pay and conditions as well as employment rates and the percentage of out of county/area employment; taking a public health perspective of morbidity and mortality; analysis of census data 1991 and 2001; future environmental changes such as additional housing, new transport infrastructure; influx of refugees and/or asylum seekers; deprivation data; cost of living data; etc]

The Current Workforce

- 1.4.1 An overview or summary of the existing workforce to include growth/expansion and gaps.

[Precise details, numbers etc in an Annex (B in this draft)]

- 1.4.2 How the balance of staff numbers/types and levels of capabilities link together across NHS, LA, Social Care, private and independent sector/prison health care eg is there an imbalance across sectors/geographical areas; is this right; does it need to be addressed and, if so, how?
- 1.4.3 Gaps/weaknesses.
- 1.4.4 Leadership and management issues/challenges.

Strategic Service Plan

- 1.5.1 To set out:
- the vision of future mental health services across primary/secondary/tertiary care and links to social care; [In broad terms over say a 5 year period but with firm details for the forthcoming year]
 - how it is different from the current configuration of services; and
 - how all the local stakeholders will get there as part of the Local Strategic Partnerships.
- 1.5.2 To set out what users and carers want from mental health services and how the Strategic Service Plan will meet such needs.
- 1.5.3 To set this in the context of the NSF, the NHSP and the *National Standards – Local Action targets* and how the Local Delivery Plan (LDP) will help deliver this.
- 1.5.4 Describe the link between the PCT(s) Commissioning Plan(s); the Mental Health Strategic Service Plan; the Financial – Investment Plan; and the HR Plan for the Trust and other stakeholders.

[Full details of the Strategic Service Plan can be included in an Annex (C in this draft)]

The Future Service Models and Workforce

- 1.6.1 Illustrate the likely capabilities, knowledge, values and skills of the workforce of the future as well as type/number of staff required in each service component specified in the Strategic Service Plan.

[Further details in an Annex (D in this draft)]

- 1.6.2. Estimate what the likely impact will be on the number of future training commissions and the effect on Continuing Professional/Personal Development (CPD).

Recruitment, Retention and Returners (R,R&R)

- 1.7.1 Describe the broad issues around R,R&R.

[Precise details in an Annex (E in this draft)]

1.7.2 Set out the where staff of the future will come from and compare to past trends.
[ie the supply side of the equation]

1.7.3 Describe the likely impact of New Ways of Working and New Roles and how these link in with service improvement and the modernisation agenda.

1.7.4 Describe the likely impact of the new Mental Health Bill.

Education and Training (E&T)

1.8.1 Present a summary of the current position around E&T commissioning, provision and evaluation.

1.8.2 Summarise lessons learnt/next steps from any Learning/Training Needs Analysis undertaken.

1.8.3 Describe what service users and carers want from the E&T system and how these are to be met.

1.8.4 Set out the key challenges for the future and how they might be achieved.

[Further details can be included in an Annex (F in this draft)]

Information Technology (IT)

1.9.1 Describe the current IT capacity, supply and modernisation across all stakeholders, the constraints and how these are to be addressed.

[Even within a trust, IT systems may be incompatible let alone between the NHS, LAs and the voluntary sector for example. What are the problems and what are the potential solutions? Try to keep this short!]

Action Plan

1.10.1 To summarise the key issues, challenges and future direction of travel of the Joint Workforce Plan supported by an agreed Action Plan setting out what is to be achieved and by when.

[Further details of the Action Plan can be included in an Annex (G in this draft)]

Once the skills and numbers are clear, the Action Plan may need to address any mismatch; ie it will be impossible to achieve a particular level or type of staffing so team configurations may need to be adjusted to take on board new ways of working, new roles etc.

[Any recommendations across all sections of the Joint Workforce Plan can either be included here; in an Annex; or in the Summary below]

Summary

1.11.1 A review of the current position and activity of the previous year.

1.11.2 The aims for the forthcoming year to show what is to be achieved; how this will be done; how this will be measured; and the resources required.

Signatures

1.12.1 To list all the Chief Executives who are signed up to the Joint Workforce Plan.

List of Annexes

Annex A – Local Mental Health Workforce Targets: Progress

Annex B – The Current Workforce

Annex C – Strategic Service Plan

Annex D – The Future Service Models and Workforce

Annex E – Recruitment, Retention and Returners

Annex F – Education and Training (E&T)

Annex G – Action Plan

Annex A

Local Mental Health Workforce Targets: Progress

ITEM	TARGET		PROGRESS	REMARKS
Number	Date	As at		
TEAMS				
Crisis resolution teams		By 31 December 2004		
Assertive outreach teams				
Early intervention teams				
INDIVIDUAL TYPES OF WORKERS				
Primary care graduate workers		By 31 December 2004		
Gateway workers				
Carer support workers				
Additional prison in-reach staff				
Secure step down staff				
Support, Time and Recovery workers		By 31 December 2006		
Community Development Workers				

Note: This Annex simply lists the workforce targets as set out in the NSF, NHS Plan etc. It does NOT mean or suggest, of course, that the other parts of mental health services are less important or are not valued as highly.

Annex B

The Current Workforce

Staffing details

- B.1 For each component of the current service models/localities across all sectors, eg NHS/LA/private/voluntary/independent, show:
- total numbers – headcount + Whole Time Equivalent (WTE) broken down into types and grade (if appropriate)
 - the number of staff working part-time/job share broken down by gender, age and ethnicity
 - the workforce age profile
 - the workforce gender profile
 - the workforce ethnic profile

[For each of these 5 bullet points, it is not just a question of collating the existing data but of identifying past/current/anticipated/future trends over a number of years so that potential problems or issues may be identified and appropriate action taken. For example, if the trend is an increasing number of staff working part-time, then whilst the overall WTE might remain constant, there will be additional pressures around education and training as more staff have to be trained. In addition, the age breakdown may show a particular age ‘bulge’ of staff in future years.]

- by service type/location [The aim here is to map the existing numbers and types of staff to the existing service models/locations]
- numbers with MHO status, their current ages and locations.

[To take an extreme example, are say 70% of staff with MHO status in one geographical patch? This makes the position of ‘early’ retirement different than if there is an even spread across the locality.]

[Not all the appropriate data will be available currently so the Action Plan may need to show how this can be achieved or completed in a staged process, starting with NHS staff; LA staff; voluntary sector staff; private sector staff. This may take quite some time and effort to complete. Cross refer to the section on Information Technology. How can the Durham database help? Is there consistency across the locality about how staff are counted? Is this co-ordinated at SHA/WDD level?]

Skill mix

- B.2 Set out the skill mix between staff across the locality broken down into individual types and grades of staff. What is the position in terms of services and geographical locations?

Vacancy details

B.3.1 For each type of staff, show:

- number of vacancies
- rate of vacancies
- the service locations – hotspots (eg acute in-patient units)
- trends.

B.3.2 A paragraph setting out the details of any long-term vacancies and any difficult to recruit posts/localities might be helpful.

B.3.3 Show what action is being taken/proposed to close the vacancy gaps.

Staff turnover

B.4 Details of staff turnover (numbers/rates) by each staff group.

[This should prove helpful information in monitoring what is happening on the ground, perhaps with local ‘targets’ being set to reduce this. It may also be useful to take this further by providing details of staff turnover by geographical patch and by service provision. (If turnover is found to be very high, eg in an acute ward setting or in a Community Mental Health Team (CMHT), why is this? Is it because of excessive stress in the former or poor management in the latter? This leads to the next question – what needs to be done to rectify this or provide the ward staff/CMHT management with appropriate help and support?)]

Use of locum – agency staff

B.5 Show the numbers, types of staff, costs and action being taken to reduce the reliance on such staff, including:

- why they are being used
- numbers/types
- frequency [are existing staff numbers or patterns of work being used to best advantage to avoid or reduce use of locums, etc? Are locum staff etc working across the board or just to help manage peaks of work?]
- localities/types of service
- costs
- what impact is this having on services users; staff; and the organisation?
- action to reduce
- use of NHS Professionals.

Annex C

Strategic Service Plan

C.1 Set out the details of the Strategic Service Plan to show:

- the vision of future mental health services across primary/secondary/tertiary care and links to social care [In broad terms over say a 5 year period but with firm details for the forthcoming year]
- each of the future elements of the service models/locations
- how each of the separate parts feeds into a holistic, whole service approach based on a mixed economy of care and a population needs analysis
- how each of the separate parts feeds into the service user care pathway [a diagram may help here]
- how each of the separate parts supports particular client group concerns [eg black and ethnic minorities; dual diagnosis; people with learning disabilities or those who are deaf and/or have physical disabilities; women's services, etc]
- how the Strategic Service Plan is supported by service users and carers [any surveys/consultation undertaken?]
- where primary care and pharmacy services fit into the new model of services
- how New Ways of Working and New Roles will contribute to the Strategic Service Plan
- how each of the key stakeholders fit into or contribute to the future model [eg the NHS; social services; social care to include the private and voluntary sectors]
- how the services are different from the current service model and how such change will be achieved and over what timescale(s)
- what the changes mean for the workforce and the organisation [eg additional numbers; new roles and/or new types of workers; re-deployment; (re-)training issues; transportation issues etc]
- how such changes have been negotiated with the staff side representatives/trade unions.

Annex D

The Future Service Models and Workforce

[This Annex should provide the detail behind the vision of future mental health services (see Annex B) across primary/secondary/tertiary care and links to social care to include the private and voluntary sectors.]

- D.1 For each component of the future service models/localities, the starting point for the development of a Joint Workforce Plan should show:
- primarily what functions and service interventions need to be undertaken
 - what capabilities, knowledge and skills are required for staff to undertake those functions and interventions in the various units
 - how each unit or setting feeds into the service user pathway.

[To help with this process, the Ten Essential Shared Capabilities may be used along with the National Occupational Standards for Mental Health and the NHS Knowledge and Skills Framework²¹]

- D.2 Describe how the functions that need to be undertaken and the capabilities, knowledge and skills required can be matched to both existing types of staff, new or emerging roles and new ways of working to determine the skill mix required, leading to an assessment of the numbers and types of staff required.
- D.3 Set out the numbers and types of staff that will be required in the new service settings for each of the next 5 years with their respective capabilities, knowledge and skills.

[The staffing of future service models should not be based simply on needing X more of Y current types of staff, rather it provides an opportunity to take a more radical approach based on functions, capabilities and skills, New Ways of Working and New Roles. This, in turn, will help to provide the basis of an education and training strategy by making it more transparent what current capabilities, knowledge and skills are held and what the gaps are.]

[The future service models will, to a large extent, but not exclusively, be determined by those set out in the National Service Framework for Mental Health and the NHS Plan. There should also be plurality of provision across sectors.]

21 DH (2004) *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process (October 2004)*, Ref 40440, DH, London.

Annex E

Recruitment, Retention and Returners

- E.1 Set out the key challenges, how these might be met and current progress.
- E.2 Set out the historical trends and likely requirements for the future.
- E.3 Describe what action has or is being taken to ensure the staff reflect the make-up of the black and ethnic minority population being served across the locality.

Recruitment

- E.4.1 Describe what action is being taken to recruit staff (eg newspaper adverts; visits to local schools/colleges; recruitment fairs/bus; development of starter homes; adoption of IWL standards; development of local champions; use of nurse cadet schemes; improved recruitment procedures such as on-line methodologies etc). [Has any evaluation been conducted to show the most productive routes? Do application forms ask how the person heard of the job?]
- E.4.2 Describe how local organisations are working together to recruit staff so as to make best use of scarce resources, expertise etc.
- E.4.3 Set out the full costs of recruiting staff, broken down into their component parts. How might this be reduced/simplified?
- E.4.4 Current position:
 - numbers/types coming through adverts/visits etc (including age; academic level; gender; ethnicity)
 - numbers/types coming through schools/colleges/sixth form academies (including age; academic level; gender; ethnicity)
 - numbers/types coming through Higher Education Institutions (including age; academic level; gender; ethnicity) [Does this match expectations?]
 - numbers/types coming through international recruitment (including age; academic level; gender; ethnicity)
 - numbers/types coming through nurse cadet/rotational schemes (including age; academic level; gender; ethnicity).

[All this information should be compared with past trends.]

- E.4.5 Set out any particular hard to fill posts and what might be done to improve the situation.

Retention

E.5.1 Show the current **sickness/absence** data:

- rates
- numbers on long-term sickness and the length of absence [what is the 'average' or 'norm?']
- types of staff
- service settings [eg is there more sickness in a particular service setting and, if so, why is that? What can be done to reduce it?]
- action being to reduce sickness/absence.

E.5.2 How does this compare to past trends? [ie are sickness rates going up? If so, why and what can be done about it?]

E.5.3 Describe what measures are being taken to retain staff and how the Improving Working Lives initiative is helping.

[eg meeting educational and training needs; adoption of flexible working practices/hours/shift patterns; negotiation of local discounts on transport; offering long service rewards; improvement of career and/or personal development paths etc]

E.5.4 What is the current age/retirement profile by numbers, types of staff and locations? Does this match past trends? What are the future trends?

E.5.5 Describe what **exit surveys** are undertaken, what the results are and how the issues are being addressed.

E.5.6 Tabulate the **staff turnover** to show:

- rates
- types of staff
- service settings [is it worse in one or more settings than elsewhere? If so, why is that?]
- what proportion of staff this represents [is turnover going up? If so, why and what can be done to reduce it?]
- action being taken to reduce turnover to include any locality targets.

E.5.7 Describe how adoption on New Ways of Working might contribute to retention of staff.

[eg time off for research; changing working practices such as clearer referral protocols etc]

Returns

E.6.1 Action being taken:

- ‘Keep In Touch’ forums/newsletters/network
- advertising
- re-training
- induction
- appraisal
- age/gender/ethnic profiles
- reasons why coming back.

Note: Two pieces of work on R&R are in the process of being published and provide a useful resource. The first is about R&R of staff to mental health organisations and the second is about R&R to mental health education and training programmes.

- Mental Health Workforce Recruitment and Retention Research Project: November 2004: University of Central Lancashire: www.uclan.ac.uk
- Choosing to Work in Mental Health: The Recruitment of Health and Social Care Professionals: September 2004: sara.owen@nottingham.ac.uk

Annex F

Education and Training (E&T)

- F.1 Describe or set out the current E&T attainment/qualifications of the staff.
- F.2 Describe the current process how staff (from all stakeholders) apply for, obtain funding for and the priorities for pre- and post-registration E&T to include recommendations for improvement.

[eg if it is on a rather ad hoc, first-come, first-served basis by each mental health stakeholder working independently, can a more collaborative process be set up across organisations/agencies to make it more systematic, to meet the needs of both individual members of staff and to address what the team/organisation needs?]

- F.3 Describe the detailed results of any Training or Learning Needs Analysis undertaken and next steps being taken.
- F.4 Provide details of the current E&T commissions to show:
- types of E&T, who commissions it and who can access it [eg which staff groups]
 - how the Ten Essential Shared Capabilities are fed into the commissioning and provision of E&T
 - costs (annual and by course/module)
 - how E&T meets the needs of staff/the organisation/service users and carers
 - who the providers are
 - attrition rates (by course/module; provider)
 - reasons
 - action to reduce
 - what quality assurance and evaluation of the E&T is undertaken – describe how the Mental Health Education Quality Improvement Tool is used to support more effective commissioning and provision of E&T.²²
- F.5 Describe the links with:
- staff – how their views on E&T are sought
 - Workforce Development Directorates/Confederations
 - Higher Education Institutions
 - other E&T providers
 - Skills for Health

²² Brooker, C and Curran, J (2005) *National Continuous Quality Improvement Tool for Mental Health Education: Handbook and Implementation Guide*, University of Lincoln, Lincoln.

- TOPSS
 - Learning and Skills Councils
 - service users and carers and how they contribute to E&T.²³
- F.6 Describe the development process and monitoring of practice placements.
- F.7 Describe what developments are taking place to use practice based learning and/or practice educators.
- F.8 Describe what use is being made of distance learning to include use of IT.
- F.9 Describe what action is being taken to promote lifelong learning and to encourage the use of Professional/Personal Development Plans. What support is provided to individual members of staff and managers?
- F.10 Describe what Leadership and Management training is available; to whom; how it is accessed; and what the funding arrangements are.

Note: The Strategic Learning and Research Advisory Group (StLaR) is currently conducting a consultation exercise in support of its aim to ensure effective joint working and strategic planning across all learning and research issues in health and social care. Although not mental health specific, it may be worth looking at the website at www.stlarhr.org.uk

²³ Tew, J, Gell, C and Foster, S (2004) *Learning from Experience. Involving service users in mental health education and training. A good practice guide*, Mental Health in Higher Education, National Institute for Mental Health in England and Trent Workforce Development Confederation, Nottingham.

Annex G

Action Plan

G.1 An Action Plan in matrix form to show:

- action to be taken
- the priorities
- timescales (ie what is to be done by when)
- who is responsible for each item in the Action Plan
- the support they are going to need
- the resources required
- measures of success
- recommendations
- how this fits into the Joint Workforce Plan.

Appendix G – Example job descriptions

Example one

1. JOB DETAILS

Job title: Workforce Planning Officer

Grade:

Hours: 30

Contract: Permanent

Location: Human Resources Department

Responsible to: Head of OD & HR

Reports to: Head of OD & HR

Liaises with: Directors, Managers PCT staff, Strategic Health Authority

2. JOB PURPOSE

The post holder will maintain the powertech HR system and ensure all required reports are produced and submitted as required to the Strategic Health Authority, Department of Health (other external bodies) and internally as required to managers and other departments).

3. ROLE OF DIRECTORATE/DEPARTMENT

To provide a high-quality, cost-effective Human Resources service that maximises the potential of the workforce and enables managers to achieve both strategic and operational Human Resources objectives. If this is achieved then improved services to patients and clients will result.

4. MAIN DUTIES AND RESPONSIBILITIES

1. Oversees the input of HR data within the PCT's HR team.
2. Manages the paper flow of HR forms between managers, the HR department, the finance department and the payroll department.
3. Works with the PCT finance department, the external payroll department and others to ensure management and development of appropriate post numbers, financial codes and establishment structures.
4. Under supervision, produce all required external data reports including the workforce development strategy and the Human Resources performance monitoring reports.
5. Assist the Business Planning Manager and the finance department as required on the production and maintenance of the Local Delivery Plan (LDP).
6. To work with the Director of Human Resources and the Business Planning Manager to agree the narrative that supports both the workforce strategy and the LDP.
7. Develop HR management reporting around wastage and turnover, absence and succession management.
8. Assist Director of Human Resources in the annual staff survey process.

5. DATA PROTECTION (DATA PROTECTION ACT 1998/FREEDOM OF INFORMATION ACT 2000/COMPUTER MISUSE ACT 1990)

All staff

To ensure the confidentiality and security of all information that is dealt with in the course of performing your duties in accordance with the requirements of the Data Protection Act 1998.

Employees should be aware the Trust operates a 'Code of conduct for handling personal identifiable information'. They should become familiar with the 'Code' and keep up to date with any changes that are made. Breaches of the guidelines in the 'Code' could be regarded as gross misconduct and may result in serious disciplinary action being taken, up to and including dismissal.

To comply with and keep up to date with the requirements of legislation such as the Freedom of Information Act 2000 and Computer Misuse Act 1990.

With the addition of management responsibilities for managers

To ensure that your staff ensure that the confidentiality and security of all information that is dealt with in the course of performing their duties is in accordance with the requirements of the Data Protection Act 1998.

To ensure that your staff are aware of their obligations under legislation such as the Freedom of Information Act 2000; Computer Misuse Act 1990, and keep the staff up to date with any changes or additions relevant to legislation.

6. INVESTING IN PEOPLE/IWL

The Trust is committed to supporting the development of all staff. All employees have a responsibility to participate in regular appraisal with their manager and to identify performance standards for the post. As part of the appraisal process employees have joint responsibility with their line manager to identify any learning and development needs in order to meet the agreed performance standards.

7. EQUAL OPPORTUNITIES

The Primary Care Trust recognises diversity and is committed to equal opportunities in employment and seeks to eliminate unlawful racial, sexual or disability discrimination, to promote equality of opportunity and good relations between staff and clients of differing groups.

8. RISK MANAGEMENT AND HEALTH AND SAFETY AT WORK

Employees must be aware of the responsibilities placed upon them under the Health and Safety at Work Act (1974), to ensure the agreed safety procedures are carried out to maintain a safe environment for employees and visitors.

9. SMOKING

The PCT is a no smoking organisation. Smoking is not permitted on any of our premises.

Requirements	Essential	Desirable	How measured AF = application form I = interview A = assessment test
<p>Qualifications and Professional Training</p> <p>Educated (and achieved) to A level or equivalent (including NVQs)</p> <p>Evidence of statistical or numerical skills (eg minimum maths GCSE or equivalent work experience)</p> <p>Evidence of studying for or achieving ECDL or equivalent qualification</p>	<p>✓</p>	<p>✓</p> <p>✓</p>	<p>A</p> <p>A/I</p> <p>A</p>
<p>Experience</p> <p>Excellent working knowledge of Microsoft Office or equivalent IT package</p> <p>Knowledge or experience of National Health Service (NHS)</p> <p>Experience of working in a busy office environment</p> <p>Worked in NHS or similar public sector organisation</p> <p>Worked in HR, workforce planning or similar financial background</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p> <p>✓</p>	<p>A/I</p> <p>I</p> <p>A/I</p> <p>I</p> <p>A/I</p>
<p>Skills and Attributes</p> <p>Excellent communication skills</p> <p>Honest</p> <p>Hard working</p>	<p>✓</p> <p>✓</p> <p>✓</p>		<p>I</p> <p>A/I/ref</p> <p>I/ref</p>

Example two

XXX PRIMARY CARE TRUST JOB DESCRIPTION

1. JOB DETAILS

Job title: Workforce Planning Project Lead (NIHME Workforce Planning Pilot Project)

Accountable to: Senior Manager, Workforce Planning Project – Mental Health

Working to:

- NIHME
- XX and YY Workforce Planning Group
- Mental Health Local Implementation Team
- Workforce Development Confederation

Salary: £30,000

Base: Flexible within XX and YY

This is a one-year secondment opportunity; however, there may be an opportunity to extend this secondment further.

2. JOB PURPOSE

To work with the XXX Primary Care Trust Health and Social Care Project Team in developing a workforce plan and strategy.

To assist the project senior manager in the delivery of the overall project by taking a lead on the workforce elements of the delivery strategy.

To take lead responsibility, working with different stakeholder organisations, for ensuring that there is a consistent approach to workforce development across the north and south west of XXX and that there is full recognition of workforce issues in the development of new models of care.

To act as liaison between operational services, project team and Workforce Development Confederations and to ensure effective communication flows across all three areas.

To ensure that findings of the project are fed into health and social care service planning.

To ensure successful engagement of all stakeholders across this wide and complex range of organisations. Stakeholders will include two PCTs, one NHS Trust, social care departments, NIHME, the XXX Strategic Health Authority and Workforce Development Confederation and related organisations involved or with an interest in workforce development.

3. DIMENSIONS

The geographical coverage of the XXXX Primary Care Trust area includes A, B and C.

The range of health and social care organisations within this area includes:

- Primary Care Trusts
- Acute Hospitals
- Mental Health Trusts
- Social Services Departments
- Voluntary/charitable organisations/other relevant projects
- Independent Healthcare providers

4. KNOWLEDGE, SKILLS AND EXPERIENCE REQUIRED

	Essential	Desirable	Where tested
Education and Qualifications	<ul style="list-style-type: none"> • Degree or equivalent • Project experience 	CIPD	Application form
Skills and Abilities	<ul style="list-style-type: none"> • Proven project management and planning skills • Excellent interpersonal, verbal, written and presentation skills • Good organisation and prioritisation skills • Problem-solving skills • IT skills • Ability to understand and work with complex organisations • Tenacity and resilience • Time management skills • Ability to think and act strategically but also to manage project realities • Marketing and implementing skills 		Application form Interview
Experience	<ul style="list-style-type: none"> • Considerable experience of partnership working across organisations and disciplines 		Application form Interview
Knowledge	<ul style="list-style-type: none"> • Good knowledge of the NHS Plan and of NHS/Social care organisation and structures • Knowledge and understanding of the Health and Social Care, Independent and Voluntary Sectors workforce • Wide knowledge of different staff groups in Health • Knowledge of the range of partners and stakeholders within Healthcare 		Application form Interview
Other	<ul style="list-style-type: none"> • Able to work flexibly across three Strategic Health Authorities • Driving licence • High degree of personal motivation 		Application form Interview

5. KEY RESULT AREAS

1. Co-ordinate the production and development of comprehensive workforce plans to meet future service requirements in line with the NIMHE workforce planning project aims.
2. Ensure the co-ordination of systems for workforce planning across the Trust.
3. Ensure that relevant workforce representatives are engaged and involved in the process of workforce planning. The central importance of robust workforce planning requires that the post holder ensures that all the relevant organisations recognise the issues and are actively engaged in developing and implementing effective solutions, that suit local needs but are coherent across the sub-region and more widely.

6. COMMUNICATIONS AND WORKING RELATIONSHIPS

The post holder will report to the senior manager for the project, working closely with the relevant workforce planning leads from NIHME and the WDCs.

The post holder will work with all partners and stakeholders on the NIHME Workforce Planning Group, Workforce Development Confederations, organisations from the NHS, social care and education, spread across the health economy.

7. GENERAL TERMS AND CONDITIONS

All employees are subject to the requirements of the Health and Safety at Work Act. The post holder is required to ensure, as an employee, that his/her work methods do not endanger other people or themselves.

All employees are subject to the requirements of the Data Protection Act and must maintain strict confidentiality in respect of patient and staff records.

All employees must comply with the Equal Opportunities Policy and must not discriminate on the grounds of race, colour, nationality, ethnic or national grounds, sex, sexuality, marital status, disability, age, or any other grounds that cannot be shown to be justified.

8. JOB DESCRIPTION AGREEMENT

Job Holder's Signature:

Manager's Signature:

Example three

NIMHE XXX & YYY WDD – Joint Post

MENTAL HEALTH WORKFORCE PLANNING AND DEVELOPMENT PROJECT MANAGER

JOB DESCRIPTION:

Title:	Mental Health Workforce Planning and Development Project Manager – up to 12 months' secondment or fixed-term contract for 12 months
Grade:	To be determined
Salary range:	Circa £35,000 or pro rata as appropriate
Accountable to:	Mental Health Lead, YYY WDD for day-to-day management, and to the Director, Training, Education & Development, National Institute for Mental Health – XXX, for national programme issues
Work base:	TBC and will involve travel within the area of the YYY Mental health economy
Hours:	Full time up to 37 hours negotiable
Main purpose of the job:	This post is jointly funded by the YYY Workforce Development Directorate and the National Institute for Mental Health XXX region. The post holder will co-ordinate the development of a workforce development strategy for Mental Health services in the YYY area in line with the National Mental Health Workforce Development Strategy, the county-wide Local Delivery Plans, and National Service Framework (NSF) implementation programmes. The Post would act as the liaison point between NIMHE XXX, YYY WDC and the local YYY Mental Health Economy. The key aim would be to increase capacity to enable the WDC and NIMHE to work together to implement the National Mental Health Workforce Strategy across YYY.

MAIN DUTIES AND RESPONSIBILITIES:

- Working across the three counties to lead on implementation of the National Mental Health Workforce Development Strategy and the Changing Workforce Programme pilots.
- To support new ways of working to include role redesign and adoption of the Changing Workforce Programme techniques in support of service delivery.
- To promote and support the introduction of new roles in mental health, eg Support, Time and Recovery workers, Graduate Mental health workers, Community Mental Health Gateway workers in support of new ways of delivering services.
- Providing project management support to the level of approximately one day per week to the Integrated Mental Health Workforce Planning Pilot in the Mental Health Partnership Trust.
- Supporting the roll out and dissemination across YYY of findings from above project.

- Liaising with the Sainsbury Centre for Mental Health and NIMHE's Joint Workforce Unit.
- Assisting in the development of a strategic approach to assessing training priorities for commissioning and planning for investment of WDC funding to support pre- and post-registration/multi-professional programmes.
- Leading on the facilitation of evaluation of Higher Education Provider programmes using the National Continuous Quality Improvement Tool for Mental Health.
- Supporting the design and implementation of new roles/teams and developing education and training programmes to underpin these: an example of such work already being carried out is the Support, Time and Recovery worker, Early Implementation sites. Other examples could be to develop education and training to support the new teams, for example, home treatment/crisis resolution and early intervention which are Trust priorities for meeting targets.
- To investigate existing models of care both locally and nationally to ensure that examples of good practice and improving models of care to patients are shared and adopted within NSC.
- To liaise closely with the Local Implementation Teams to ensure that the strategic workforce plan ensures adoption of the key recommendations of the National Service Frameworks for mental health and other relevant service areas, eg children and older people.
- Support mental health and social care organisations to develop best practice in the employment of people who use or who have used mental health services.
- With SHA colleagues to investigate and access funding from internal and external sources in support of workforce development. This would include responding rapidly to support any future bidding process for early implementation sites or pilot sites that require WDD and NIMHE approval such as occurred with the national personality disorder and the Workforce Planning Pilots.
- To liaise with local workforce and service planners in the investigation, clarification and resolution of current and future workforce recruitment and retention pressures.

MAIN CONTACTS:

- YYY Strategic Health Authority staff.
- Mental Health Partnership Trust staff.
- YYY Mental Health Trust staff.
- ZZZ Mental Health Partnership Trust staff.
- National Institute for Mental Health in England staff.
- Staff in NHS organisations and Social Care employers.
- Voluntary and independent sector employers/staff.
- Staff in Higher Education Institutions and other Educational establishments.
- Other Government or external organisations with an interest in employment and health services.

This job description may be subject to alteration in the light of future changes and developments.

NIMHE XXX and YYY WDD

Mental Health Workforce Planning and Development Project Manager

Person Specification

		Essential	Desirable
Qualifications	Degree level or equivalent	✓	
	Professional qualification/registration		✓
Knowledge and skills	In-depth understanding of Mental Health policy and practice, particularly in relation to workforce development	✓	
	Use of databases and spreadsheets including Excel	✓	
	Excellent presentation skills for small and large groups	✓	
	Excellent verbal and written communication skills	✓	
	Ability to gain confidence and influence	✓	
	Negotiating skills	✓	
Experience	Work in a clinical setting with links to mental health Service/workforce development and innovation		✓
	Involvement with workforce strategic planning		✓
	Experience of project management	✓	
Personal attributes	Tenacity		✓
	Energetic/proactive	✓	
	Methodical and well organised	✓	
	Collaborative	✓	
	Analytical mind	✓	
	Able to set and work to objectives	✓	
Other	Car driver/owner	✓	

Example four

ZZZ NHS TRUST

JOB DESCRIPTION

1. JOB TITLE: Workforce Development Facilitator

RESPONSIBLE TO: Assistant Head of Human Resources
(Workforce Development)

2. ROLE PURPOSE:

- 2.1 To inspire and facilitate the modernisation of our workforce to meet the strategic aims of the Trust and requirements of the NHS Plan, the HR Strategy, National Service Frameworks and Adult and Older People Mental Health Services and all other services not directly covered by National Service Frameworks.
- 2.2 To coordinate the systems of workforce planning across the Trust, working with the Development and Training Workforce Development Confederation, Trust Managers and other stakeholders.

3. KNOWLEDGE, SKILLS AND EXPERIENCE:

- 3.1 Minimum of three years' experience in the NHS desirable with some experience of staff training/teaching/facilitation.
- 3.2 Proven facilitation skills preferably developed through a background in clinical/supervisory position, staff training or Human Resources.
- 3.3 Ideally will have an understanding of workforce development issues in Mental Health/Learning Disabilities, NHS workforce planning process, competency frameworks.
- 3.4 Good interpersonal, influencing, oral and written communication skills essential.
- 3.5 Report writing and presentation skills essential.
- 3.6 Car owner/driver essential.

4. OUTLINE RESPONSIBILITIES:

- 4.1 To inspire, initiate and support the development of models of workforce development and planning across professions, care groups and agencies, which will underpin the Trust modernisation agenda.
- 4.2 To build networks locally and nationally to keep up to date with best practice on workforce development and disseminate this information across the Trust.
- 4.3 To build relations with front-line managers, clinicians and support staff to engage them in the development and planning of our future workforce.

- 4.4 To identify pathways of care for Trust client groups, to identify those competencies required to deliver care along this patient care pathway, translating the skills needed into appropriate roles, identifying best fit with either existing or new roles.
- 4.5 To identify a mechanism for assessing the current skills and competencies available against those needed, and undertake a gap analysis in relative skills.
- 4.6 To help ensure that an accurate assessment of the existing workforce across all areas is available and accessible to managers in planning their service.
- 4.7 To support the development of a skills profile analysis of the current and future workforce, working with key colleagues internally and Workforce Development Confederation advisors.
- 4.8 To act as a focal point within the Trust for managers and clinical leads around workforce planning and development ensuring information and plans are handled in a co-ordinated and systematic way.
- 4.9 To ensure the provision of effective workforce planning systems and policies and to provide technical support and advice as appropriate to the development of software in support of the workforce planning process (such as View-Based Systems adopted within the Trust).
- 4.10 To work with the information officer, Personnel Colleagues, line managers and the Workforce Development Confederation advisors to continually improve the Workforce Information Systems, to best meet the needs of the service.

	Essential	Desirable
Education and Qualifications	Professional qualifications or equivalent	Experience of staff training/teaching/facilitation Minimum of three years' experience in the NHS – some of which at supervisory level
Knowledge		Understanding of the workforce development issues in Mental Health/Learning Disabilities, NHS workforce planning process, competency frameworks
Key skills	Good interpersonal, influencing oral and written communication skills Report writing and presentation skills Car owner/driver essential	
Personal Attributes	Flexible approach	

Appendix H – Engagement of general managers and service heads

Best practice

Covering letter

To general managers/service heads

Re. Workforce development plans

Please find enclosed the relevant documents and guidelines to assist in the production of locality workforce plans 2005/06. This process is in alignment with the trust-wide LDP and process planning timeline. There are two documents for completion, which are the workforce development plan and a skills Matrix. There are guidelines for both of these. Throughout this process please contact XXX if you require assistance or advice.

The skills matrix is a way of capturing information about the skills of our current workforce so that we can look at the requirements of the service and analyse the gaps. It also provides an opportunity to look to the future and the Trust Advance project, and to the future needs of your service as far as skills required by staff to deliver care in these areas are concerned.

Guidelines

WORKFORCE DEVELOPMENT PLAN (2005)

1. CURRENT STAFF (WTE)

Please ensure that actual and full numbers are identified. If there are staffing groups not identified please ensure that you add them to the list.

2. CURRENT WORKFORCE ISSUES

Please report any current themes that are relevant to your workforce, such as recruitment and retention issues, training and competency issues, morale and sickness. Please also include links to statistics and/or surveys.

3. WHAT ARE THE DEVELOPMENT PLANS FOR THIS TEAM? (INDICATE DATES)

Please outline the team development plans. They must include 2004/05 but can cover three years if they are identified in the LDP. Please include examples from your 'advance', Agenda for Change and LIT developments.

4. WHAT ARE THE GAPS IN WORKFORCE NUMBERS, SKILLS, ETC?

This is where we need detailed information, eg numbers and skills deficits, vacancy numbers, etc.

5. HOW TO BRIDGE THE GAPS (NEW ROLES, TRAINING, REDESIGN, ETC)

Please give detailed information on the redesign of roles, New Roles, New Ways of Working, training needs, etc. Please give consideration to a career framework or skills escalator for all staff.

6. RED/AMBER/GREEN AND WHY?

Red – Failure to meet

Amber – Inconsistent

Green – Consistent

SKILLS MATRIX

This is a way of capturing information about the skills of your current workforce and gaps in their training and development needs. Include current and future skills that will be required to provide care to the client group.

Coding system

0 = skill not required

1 = skill needed – training/development required

2 = skill acquired/training undertaken or being undertaken

[Editor's note:

1. The following 'Illustrative example of a completed skills matrix' tabulates, for each member of staff, what their individual position is in relation to the coding system set out above. This can be broken down in a number of ways, eg to show how many staff need to undertake a particular piece of training and the total number who have already completed it. This will help to inform future education and training requirements and funding.
2. What it might also show, for example, is the (large) number of staff who have already completed training in either cognitive behavioural therapy (CBT) or psycho-social interventions (PSI). This might then beg the question of (a) why, if so many staff are already qualified in these areas, is there a shortfall in the actual delivery of CBT and PSI – does the delivery model of mental health services need to change?; and (b) why then is the Trust wanting to invest more training resources in this area?
3. From the information gathered and from analysis, Tees intends to establish a list of core skills for each group of staff, eg nursing assistants, that will be consistent across the whole trust. In addition, Tees intends to identify a list of skills for each staff group, eg occupational therapists, that are specific (in this case) to a clinical area or clinical team. The final stage is to identify those staff who have extended their skills and knowledge and who will be able to provide specific therapies **across** the trust, eg CBT.
4. For further information, contact Judith Hurst, Workforce Development Facilitator at judith.hurst@tney.northy.nhs.uk

ILLUSTRATIVE EXAMPLE OF A COMPLETED WORKFORCE DEVELOPMENT PLAN (2005) MATRIX

LOCALITY/SERVICE NAME HERE: XXX – ADULT INPATIENT UNIT

Team name and location	Current staff (WTE)	Current workforce issues	What are the development plans for this team? (Indicate dates)	What are the gaps in workforce numbers, skills, etc?	How to bridge the gaps (new roles, training, redesign etc.)	Red/amber/green – and why?
Anywhere ward – St Luke's Hospital	Managers – G	Turnover rate is 20%.	Further develop OT role on unit – July 2005.	Currently have three vacancies – one F-grade, one D-grade, and one A-grade.	Training plan for current E-grade staff nurses to prepare for F-grade role.	
	Nurses – A to B	Recruitment of grade Fs is difficult.	Rotation of staff nurses from inpatients to the community for broader experience – ongoing.	See skills matrix to see current deficits for future needs.	Utilise D-grade/A-grade monies to recruit 'new role' – two assistant practitioners.	
	Nurses – C to F	10% of nursing staff to retire in 2005/06.	Develop specialist skills within the team, eg dual diagnosis/drug and alcohol/PSI – ongoing.		LDP monies available 2005/06 to introduce two STR workers.	Amber
	Consultant psychiatrist	Only 70% of staff are stat trained.	Increase core and specific skills – deficit identified – see skills matrix – July 2005.		Role re-design: one N/A into activities co-ordinator.	
	Psychiatric trainees/SHOs	Recruitment is mainly internal and from university.	Succession planning with E-grade staff nurses – ongoing.		Liaise with OT department about the strategy for OT inclusion.	
	Occupational therapists	Sickness is high in this area – 12%.	Introduce STR worker – July 2005.			
	Administrative workers/ward clerks	Fair morale based on last staff survey.				
	Volunteer staff	Generally good competency-based skills for current role.				
	Approved social workers	0				
	Actual staff numbers	31				
	Full complement budget	34				

ILLUSTRATIVE EXAMPLE OF A COMPLETED SKILLS MATRIX

Adult inpatient unit XXX													
Name	Staff grade or title	PSI Basic	PSI Intermediate	PSI Advanced	Risk Assessment	Risk Management	Brief Solution Therapy	Anxiety Management	CBT Basic	CBT Intermediate	CBT Advanced	Etc	Etc
	Acting G-grade	1	2	1	2	2	1	2	2	1	1		
	Staff nurse	1	2	1	2	2	1	2	2	1	1		
	F-grade	2	2	1	2	2	1	2	2	1	1		
	Acting F-grade	1	1	1	2	2	1	2	2	1	1		
	Nursing assistant	0	0	0	1	0	0	0	0	0	0		
	Nursing assistant	0	0	0	1	0	0	0	0	0	0		
	STR worker	0	0	0	1	0	0	0	0	0	0		
	Etc												
	Etc												
	Etc												
		3	1	4	3	0	4	0	0	4	4		
		1	3	0	4	4	0	4	4	0	0		

Appendix I – Staffing data

Durham database

1. One of the original aims of the WPPP was ‘to consider how the service mapping database hosted by Durham University could feed into workforce planning’. It soon became clear to the pilot sites, however, that data supplied to and held by Durham was organised for a specific purpose around the monitoring and performance management of the *National Standards, Local Action* framework.²⁴ The database does not provide an appropriate or comprehensive enough type or level of information that is needed for integrated joint workforce planning purposes.

Purpose of Appendix I

2. The purpose of this appendix is to provide more guidance and advice about collection and analysis of staffing data than was contained in the 2003 publication *Mental Health Services – Workforce Design and Development: Best Practice Guidance*, in the light of WPPP experience.

The stages

3. Although the original guidance is still relevant, what it did not contain was a clear statement about the separate stages that need to be understood and implemented when taking forward a workforce plan. In very simple terms, these stages are:
 - collection and consistency of data;
 - analysis of current data and past trends;
 - estimating supply;
 - inclusion of this information and analysis as part of the overall workforce plan.

Stage 1: Collection of data

4. In Stage 3 of the Workforce Planning Model set out in pages 9 to 11 of the best practice guidance, (‘Reviewing Current Services and Workforce’), paragraph 29 referred to the core data required across the NHS, local authorities, voluntary services etc. The text was supported by two ‘spreadsheets’ in Annex B, suggesting how the current workforce data might be collated. The relevant ones were:
 - B4.1 – current workforce by service component (broken down by types of worker and service settings);
 - B4.2 – current workforce: collated data (broken down by types of worker, 10-year age bands and ethnic background by gender).
5. The ‘spreadsheets’ were only intended to be illustrative, but it is clear that some localities are using them to put their workforce data together. However, what may seem to be a relatively simple task is, in fact, more complex.

²⁴ DH (2004) *National Standards, Local Action: Health and Social Care Standards and Planning Framework: 2005/06–2007/08*, DH, London.

First task

Each stakeholder organisation should know:

- what data is collected;
- why it is collected (ie for whom);
- on what basis it is collected (ie by what definition, category or 'bandings', eg ages 20–30, etc);
- by whom it is collected, eg HR, finance, service managers (and if there is an overlap between them, how consistent the data is);
- at what frequency it is collected;
- how it is collected (eg in a paper or electronic format, and whether this is consistent across the organisation);
- what happens to the information (ie what use is made of it – who uses it);
- how robust or reliable it is.

Second task

Each stakeholder organisation should:

- be clear about what it doesn't know;
- decide how important or necessary it is or might be to collect such data – see below;
- know if such data can be collected within its existing system(s);
- understand what additional resources (if any) – both human and financial – would be required to collect such information.

The reason for this second stage is that, if it is to be successful, workforce planning cannot be done in isolation from other partners. It is possible that an organisation may be asked to start collecting new or changed data as part of the wider collaborative arrangements – see below.

Voluntary sector

6. The pilot sites have recognised the difficulty of collecting staffing data from the voluntary sector – see, for example, 'Engaging the independent and voluntary sectors' in Appendix C.

Best practice: A number of the pilot sites have taken a stepped approach trying to capture data, using a mixture of encouragement and the provision of support. For example, they will agree to fund some education and training in return for information, but will also provide a simple questionnaire for the organisations to complete. Two examples of this type of questionnaire are at Annex A (covering letter and questionnaire) and Annex B (questionnaire only) respectively.

Local authority (LA) staff

7. It needs to be made clear how LA staff are to be recorded and included for workforce planning purposes – particularly where such staff are not included in the NHS trust payroll systems.

Stage 1 (continued): Consistency of data

- 8.1 It is often difficult enough to achieve consistency **within** an organisation in how staff are counted, and this is not helped by incompatible IT systems within a trust. This is particularly true when the organisation is the product of several mergers.
- 8.2 It is even more difficult to achieve consistency between two local organisations (NHS trusts and LAs, for example) and between local organisations and regional or national bodies (eg NHS trusts, SHAs and DH). The trick is for each organisation to clearly set out the information in Stage 1, and to share it with the other stakeholders in the WPG or LIT. Ideally, all the relevant stakeholders should be represented on the WPG or LIT.
- 8.3 Common ground (or definitions/categories/bandings) should be established in the first instance. And while at first sight it may seem sensible to automatically collect and share such information for the future, it needs to be formally agreed that this is the best way to proceed – see ‘Duplication of effort’ below.
- 8.4 The next step is to identify what is different between the stakeholders, and to establish what or who might change – either in the short or long term. (This does not always have to be done at once.) For example, the WPG should:
- decide on what ‘bandings’ might be used, eg:
 - the age bands to record staff (5 or 10 years: 20–25 or 20–30);
 - the ethnic groups (the NIMHE recommendation would be to use the national ‘16+1’ census categories, as this would provide some consistency with other users and processes – eg ethnic monitoring – avoiding duplication of effort);
 - reach agreement on the definitions of staff **across agencies**. In one PCT, managers were counted on the basis of their **management** qualification, but in another they were counted on the basis of their **professional** qualification (eg as a nurse). And yet they were carrying out exactly the same function.
- 8.5 These are just some examples – there may well be more where greater consistency across local stakeholders is required.
- 8.6 There can be additional difficulties in respect of those staff who don’t have a single, ‘natural’ home – ie who work across services or different age groups. One example would be an occupational therapist (OT). This needs to be clarified and agreed.

Duplication of effort

- 9.1 Under the present system, as part of the aim to achieve greater consistency, an element of duplication is occurring. This results from the many requests for workforce data, which often come at different times and from a variety of sources, including DH, SHAs and PCTs. There is a considerable burden for providers, and it can also be difficult for workforce planners to know on what basis and at what level of detail they should be collecting and collating workforce data for their own purposes.

- 9.2 It is clear that SHAs/WDDs use their own templates and layouts to collect workforce information. This ranges from the broad – eg WTE numbers in post, retirements, expansions, and contractions – to the more detailed. For example, more detailed information might include not only the four items above but also some or all of the following:
- head count figures;
 - vacancies;
 - a breakdown of all the individual new and emerging roles in MH or the percentage of work moving across staff types resulting from New Ways of Working;
 - more specific details of non-retiring leavers (eg those going to work overseas);
 - more specific details of joiners (eg secondments, international recruitment, return to practice etc);
 - staff turnover;
 - LDP workforce demand;
 - sickness absence;
 - bank and agency staff expenditure, etc.
- 9.3 It is not for this Report to comment on these differences save to say that it may be worthwhile for local workforce planners, working in conjunction with their appropriate SHA/WDD, to be clear about what the current requests are, when they occur and the basis or categories being used. The aim would be to ensure that there is as little duplication as possible, so that data collected at every level meets the need of that particular level and also the next level up. Where possible, the timescales should be concurrent, so that providers are not being repeatedly asked for the same or similar information. (This is the rationale behind the introduction of the Skills for Care Minimum Data Set referred to in Appendix K.)
- 9.4 If an NHS trust collects staff numbers in 5-year age bands, and the SHA/WDD wants such information in 10-year age bands, but their colleagues in the LA and the voluntary sector do not collect numbers in any form of age banding at all, would it be possible for **all** the stakeholders to move to a 10-year age band (all starting at the same age point of course!)? This would not only make local workforce planning easier across stakeholders, but would also provide information ‘upwards’ or in parallel with no extra effort or duplication. Another example is for everyone to use WTE or head counts, and not a mixture, wherever possible.
- 9.5 Duplicate requests for data can be challenged by the NHS at any time. Such requests from DH may be referred to DH external gateway or the Review of Central Returns (ROCR) in order to challenge burdens and propose solutions. Where such requests are from within the NHS, they may be referred to the local NHS gateway contact. See www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/ReducingBurdens/Gateways/fs/en for details.

Stage 2: Analysis of current data and past trends

10.1 The work does not end with the collection of robust data – important though that is. What workforce planners need to do is to build up ‘trend’ data so that, over time, it will be possible to see the historical trend over several years. This, coupled with an effective analysis of the potential future supply of staff, will help with the development of an effective workforce plan based on good information rather than just on ‘guesstimates’. (Although there will always be an element of that, of course.) See also Annex E in Appendix F.

10.2 Here are a few examples of the sort of analysis that trusts may wish to carry out:

- The numbers of and growth in staff working part time. Although this means little to the overall WTE numbers, more staff working part time will mean that more need to be trained – do future education and training commissions (and budgets) provide for this?
- The proportion of staff who come from BME communities. Does it reflect the growth of that community? If the proportion is static or only growing by a small percentage and yet the information from public health, WDD colleagues or the census data is that the community is growing at a much faster rate, this might indicate that the priority for any future recruitment strategy for the trust or LA should be the BME community (if future supply is to meet demand).
- The growth in both the number and proportion of staff in the over-50 age bracket. Are these increasing exponentially? (One of the WPPP sites faces the prospect of some 40% of its staff reaching retirement age within the next five years.) If so, this may indicate that the priority for any future retention programme might be on this sector of the workforce. What opportunities are there around flexible retirement – working part time after ‘normal’ retirement age?
- The number of staff currently who hold MHO status, thus allowing them to retire at 50. Are they holding really key or specialised posts that might be difficult to replace quickly? Are they spread evenly across the trust, or in one or two localities? (The latter presenting a more difficult problem than the former, perhaps.)
- The appropriate skill mix ratio for the workforce of the future, based on the patient journey. One pilot site believes it should be:
 - 10% of staff with specialist skills;
 - 60% of staff with intermediate skills;
 - 30% of staff with basic skills.

This has helped to determine the site’s future E&T programme.

- The trend for young people entering the workforce. Are the numbers under age 20 or between 20 and 30 going up, and does this match the proportion of school-leavers locally?
- The pattern of sickness rates across the trust or LA. Are there any local hot spots? Is the trend upwards, and if so, why? Does this call for some specific action by senior management?

Stage 3: Estimating supply

- 11.1 Looking at the supply side of staff is crucial, as the demographics are against the public sector (including mental health) – there will be 700,000 fewer people of working age by 2010. So there is a clear need to ‘horizon-scan’ to see what the ‘opposition’ are doing to attract potential staff.

Best practice: The Dorset HealthCare Trust has recognised that, at 18.3%, the proportion of children under 16 years old in Dorset is below the national average of 19.8%. Currently there are only 5,000 school-leavers on average per year for the whole economy. A migration of 16- to 29-year-olds could be attributed to school-leavers going into higher education and taking employment opportunities outside of the South West. The Trust needs to develop a robust recruitment and retention strategy to include a flexible approach, ‘growing their own’ through schools and higher education and offering flexible careers or placements in advance. The Trust should also assist staff who are preparing for retirement age and encourage retirees from the local population back into the workplace.

- 11.2 Mental health services must play to their strengths through implementation of the IWL initiative, and establishing good induction programmes, good provision of education and training, good career prospects and good pension provision. Mental health services should be asking themselves what needs to be done to ensure that they are seen as the employer of choice for the local community, over and above other employment opportunities.
- 11.3 This is an area where the WDD should be able to help, as it will have a wider perspective than a local NHS trust will have. However, the essentials are about the following:
- Looking at the possible supply side, using the analysis of current data and past trends as set out above – these may give an indicator of possible numbers coming through, assuming that these trends continue.
 - Looking at where recruitment takes place now, eg W% of staff are already living in the area; X% are out-of-area; Y% are international; and Z% are taken from other NHS or social care organisations. Such an analysis gives a good picture of what the local labour market looks like in reality.
 - Estimating the total number and type of school-leavers expected over the next five years, and how many might want to join mental health services. How many of these will be at GCSE level and how many at A level? What is the likely male/female split?
 - Looking to see what the numbers of local university places will be over the next five years, as well as at possible growth.
 - Looking at the growth in the local population and at what might be done to target this as part of a co-ordinated recruitment strategy. For example, is there going to be a large house-building programme as part of a wider regeneration project? Is this likely to attract new families into the area and, of these, how many are currently working in mental health and want a transfer, or how many used to work in mental health and might be interested in returning? What can be done with local estate agents to get a recruitment flyer into their literature pack, or can the show-home representative be persuaded to have the flyer on display?

- Considering the effects (good and bad) of the local transport network, and whether any influence can be brought to bear (perhaps on the basis that MH may be one of the largest employers locally) to improve the road/bus/rail network? For example, it could be that bottlenecks frequently occur at a particular time of day on the west side of the town, making it difficult for staff to travel just a few miles. It could be that there is another hospital 20 miles further west, in another trust, which is actually easier and quicker to get to because of the motorway, even though it is four times further away.
- Looking at how many of those due to retire in the next five years could be interested in coming back to work part time, either in their old job or in a brand new role. For example, a former nurse may wish to return as a part-time STR worker.
- Looking at how New Ways of Working and/or the introduction of New Roles may either encourage new recruits to join or may help to retain staff by offering them a new direction (or career).
- Looking to see if any former members of staff might be interested in returning to work (with guaranteed support and refresher training) – perhaps after their children have grown up.

Stage 4: Inclusion of this information and analysis as part of the overall workforce plan

12.1 Appendix F to this Report – An outline joint workforce plan – is relevant here.

12.2 The workforce plan should not contain pages and pages of data – it may be best to include the relevant figures as an appendix. However, it will help readers with their analysis if bar and/or pie charts are used, particularly when representing trend data. Data linked to future service plans can be set out as a series of themes (both trust- and locality-wide) to demonstrate future developments and timescales, as well as how New Ways of Working and New Roles will have an influence.

Best practice: Both the Tees and North East Yorkshire NHS Trust and the Dorset HealthCare county-wide project have some very good examples in their respective workforce plans.

12.3 The plan will need to convey the key points and trends, so that readers can get a clear picture of both the current and future position. What is going well? What are the ‘hot spots’ or difficulties, and how might these be overcome? What is fact and what is opinion based on analysis? Are there any particular areas or issues that need to be brought to the attention of the board for information, resolution or guidance? What does any ‘horizon-scanning’ indicate? For example that it might be important to flag up the forthcoming Mental Health Bill, and what the possible or likely implications might be in terms of staff numbers and types. (The new AMHP is a good example.)

Annex A

Sample questionnaires for voluntary organisations to complete

Covering letter

To: The Manager, all independent and voluntary mental health providers in XXX

Dear Provider

Mental health workforce review

As you may know, both the XXX Primary Care Trust and the council's social services department are involved in a pilot as part of a national scheme to review the mental health workforce. The aim of the project is to profile the current workforce, including its capacity, and to identify future demands on these services. The project is also seeking to address any recruitment, training or development needed in order to enable the workforce to meet those demands.

As part of this project, we need to undertake a mapping exercise of the current workforce that includes the independent/private and voluntary sectors as well as the public sector. To this end, I enclose a brief questionnaire that we hope you will complete in order to help us with this task.

Would you please complete this questionnaire for your organisation by XXX and return it to YYY by

I hope you will agree that this work will be of assistance to us all, including service users, and will help to ensure that both the workforce and provider organisations are prepared for the future. I will, of course, share the results of the project with you, and will aim to provide tangible benefits in terms of improved communications, information-sharing and joint training packages.

I should also like to take this opportunity to remind you that you will also be asked to provide workforce information later this year as part of the national Minimum Data Set. The social services department will send out further information about this exercise nearer the time.

Thank you very much for your help and co-operation.

Annex B

XXX adult mental health workforce strategy group

Workforce information survey 2005

A. Your organisation

Name of your organisation	
Named contact	
Address	
Telephone number	
Fax	
Email address	

B. Workforce information

1. Please give the number of people employed by your organisation in [year].

1.a Please give the full-time equivalent (FTE) number of your ['nursing'] workforce.

1.b Please list the category of actual employment and the FTE number of people employed in each role:

Job title	No. in post	FTE	Job title	No. in post	FTE

1.c Does your organisation provide services in more than one location? Yes No

If you answered yes, please give the number of locations: _____

2. Please list the service user group(s) for which your organisation provides services in the XXX area.

3. With reference to the service user group(s) listed at 2, please state the number of staff who are directly involved in the provision of care services in each service area.

4. Please give the number of your staff holding managerial positions who are required to hold the Registered Managers Award.

5. Please give the number of your staff holding other supervisory roles.

6. Please state your current annual staff turnover (the number of people who have left your organisation in the past year, expressed as a percentage of your total staff number).

7. Please state the number of advertised vacancies left unfilled for six months.

8. Please list these vacancies:

9. Please state the number of days of staff absence within your service during the year to 31 March 2005.

10. Please state your number of XXX staff for each of the following age ranges:

- 16–24
- 25–39
- 40–49
- 50–59
- 60+

11. Please state your number of XXX staff for each of the following categories:

- Male
- Female

12. Please state your number of XXX staff for each of the following categories:

- White: British
- White: Irish
- White: Other (please specify)
- Mixed: White and black Caribbean
- Mixed: White and black African
- Mixed: White and Asian
- Any other mixed background (please specify)
- Asian: Indian
- Asian: Pakistani
- Asian: Bangladeshi
- Any other Asian background (please specify)
- Black/black British: Caribbean
- Black/black British: African
- Any other black background (please specify)
- Chinese
- Any other ethnic group (please specify)

Are any employees covered by the Disability Discrimination Act? Yes No

If yes, please give the number of staff: _____

C. Training and qualifications

1. Does your care workforce undertake an induction that meets the standards of Skills for Care and progress to foundation training that meets appropriate standards? Induction Foundation
2. Please give the number of your staff who have achieved NVQ Care Level 2 or Level 3, or equivalent.
3. Please state the number of those currently registered for and pursuing NVQ Care Level 2, or Level 3, scheduled to complete their qualification in 2005/06.
4. Please state the number of your managers who hold the Registered Managers Award (RMA).
5. Please state the number of those currently registered for and pursuing the RMA.

Please complete the survey and return to YYY.

Annex C

Name:											
Type of service:		Day service				In-patient				Outreach	
Current staff	In-post	Vacancies (numbers)	Age range of all staff	In-post	Vacancies (numbers)	Age range of all staff	In-post	Vacancies (numbers)	Age range of all staff	In-post	Vacancies (numbers)
Managers	3		<20 1 20-24 4 25-29 6 30-39 10 40-44 15 45-49 12 50-54 10 55-59 4 60-65 4 65> 1	2	2	<20 0 20-24 2 25-29 4 30-39 9 40-44 3 45-49 4 50-54 2 55-59 2 60-65 1 65> 1	1	0	<20 0 20-24 1 25-29 2 30-39 4 40-44 6 45-49 5 50-54 4 55-59 4 60-65 2 65> 2	1	0
Nurses A-B grade	2	0		3	1		1	0		1	0
Nurses C-G grade	3	0		2	0		2	1		2	1
Social workers (qualified)	2	1		4	1		2	0		2	0
Social work assistants	4	1		2	0		1	1		1	1
Consultant psychiatrists	4	1		2	0		2	1		3	1
Psychiatric trainees	2	2		2	1		1	0		1	0
Clinical psychologists	4	0		5	1		3	0		3	0
Assistant psychologists	3	0		3	1		3	1		3	1
Psychotherapists	3	0		6	1		1	0		1	0
Counsellors	3	1		5	2		2	0		2	0
Occupational therapists (OTs)	4	0		6	2		2	0		2	0
Assistant OTs	2	1		3	1		3	1		3	1
Art/drama/music therapists	3	1		3	2		2	1		2	1
Physiotherapists and speech therapists	3	2		4	0		2	1		2	1
Support workers	6	2		2	2		3	2		3	2
Care workers	4	1		3	2		1	0		1	0
Administrative staff	3	3		3	2		3	0		1	0
Volunteer staff	4	1		1	1		1	0		1	0
Others (please specify)											

Date required by:

Linked to: AAA LIT

BBB LIT

Completed by:

CCC LIT

DDD LIT

Notes for organisations completing the table:

1. Please complete a column for each main service you provide, ie each inpatient service, residential house, day service, etc.
2. Please put in staffing totals for each type in each service in whole numbers, ie nurses C-G grade.
3. Staffing definitions provided are public sector ones; please use the ones you recognise as applying to your own staff. For any other staff use the 'other' box and tell us both number and type of staff.

What difficulties do you have in recruitment, and for what types of staff?

How are you trying to address these problems?

Do team skills/composition meet local service needs and identified developments?

How do you intend to bridge the existing gaps? (Eg identify alternative funding streams, develop existing team skills, change roles, change service model or no change needed?)

Return all forms to

Appendix J – Sample action plans

First version

Action	Responsible officer	Milestones	Completion date	Current status/comments
<p>Stage 1</p> <p>Define the locality and care group and establish the workforce team (page 7 of the best practice guidance, paras 18–19)</p> <p>1.1 Local Implementation Team (LIT) to define locality and establish workforce sub-group (WSG).</p>	Ms M		Completed . . .	WSG established.
1.2 Define client care group and ensure geographical area matched to local planning structures, eg PCT area.	Ms M		Completed . . .	Coterminous with PCT and borough council boundaries. Focus on adult mental health initially.
1.3 Identify major agencies/ organisations/professions responsible for delivering mental health care and ensure they are represented on LITs. (LIT members should have a significant and influential role in organisation.)	Ms M		Completed . . .	Represented on group.
1.4 LIT must have strong links with SHA workforce leads.	Ms M		Completed . . .	Represented on group.
1.5 Users and carers to be represented.	Ms M		Completed . . .	Represented on group.

Action	Responsible officer	Milestones	Completion date	Current status/comments
1.6 People with learning disabilities to be represented.	Ms M		Completed ...	Agreed to focus on adult mental health initially. Consider sharing of processes with other areas, including learning disabilities, older people, drugs and alcohol at a later date.
1.7 HR and finance representatives – linked to local strategic service plan (LSSP) and development of joint workforce plan.				HR represented. Finance to be consulted at draft plan stage and on the development of the local delivery plan.
Stage 2 Define demand for local mental health services (pages 7–9 of the best practice guidance, paras 20–25)				
2.1 Gather information about service demand to establish needs of local people (including mental health and learning disabilities).	Ms L and Ms D	Draft completed	Draft completed	
2.1.1 Define responsibilities for data collection.	Ms L and Ms D		Completed ...	
2.1.2 Define scope for data collection (limit to avoid being too onerous).	Ms L and Ms D			
2.1.3 Forecast demand. Either: a) identify needs of service users and forecast future changes (Annex B information); or b) Estimate demand from epidemiological data – current and ‘hidden demand’ (valuable, but only practical if resources and skills are available to make forecasts and take action needed).	Ms L and Ms D		Completed ...	Have had meeting with public health for needs assessment and liaised re. national Minimum Data Set. Also Durham information. Ditto
	Ms L and Ms D		Completed ...	

Action	Responsible officer	Milestones	Completion date	Current status/comments
<p>Stage 3 Review current services and workforce (pages 9–11 of the best practice guidance, paras 27–31)</p>				
<p>3.1 Identify and map current services.</p>	<p>Ms M and Ms P</p>	<p>Mapping of current adult mental health services by 1/11/04. Include in LSSP.</p>	<p>Completed . . .</p>	<p>All adult mental health services mapped on Durham website. Older people included in LSSP draft.</p>
<p>3.1.1 Identify service components and how they relate across primary, secondary and tertiary levels, including people with learning disabilities, mental health disorders and substance abuse, including dual diagnosis.</p>			<p>Completed . . .</p>	<p>Initial consideration given to use of MHLD toolkit and WSG established to monitor interface of services.</p>
<p>3.1.2 Identify any other considerations needed.</p>	<p>Ms M</p>		<p>End of July</p>	<p>Focus on patients' outcomes and service improvements – performance indicators.</p>
<p>3.1.3 Identify major issues and difficulties to address in LSSP.</p>				
<p>3.2 Review current workforce.</p>			<p>See below</p>	
<p>3.2.1 Include statutory, voluntary and private sectors (see 3.2.4 and 3.2.5).</p>			<p>Included</p>	
<p>3.2.2 Include profile and supply (recruitment and retention) of existing staff.</p>	<p>Training and recruitment and collaborative groups, advertising agency</p>		<p>Included</p>	<p>WSG discussed issues on 10/5/05.</p>
<p>3.2.3 Consider nature of labour markets (see paras 30–31 and Annex C and paras 1.3.8–1.3.9 of the planning guidance).</p>	<p>Training and recruitment groups, employers' forum</p>			<p>Some base labour market information collected. WSG needs to consider implications.</p>
<p>3.2.4 Complete separate core data spreadsheets (Annex B4) for each provider (NHS, local authority, voluntary sector, etc). NB Bear in mind data protection issues.</p>	<p>Mr G and Ms K</p>	<p>Core data spreadsheets for public sector considered by WSG on 22/11/04.</p>	<p>Completed for public sector 22/11/04</p>	<p>Questionnaire drafted for independent and voluntary sectors and database of providers drafted (see below).</p>

Action	Responsible officer	Milestones	Completion date	Current status/comments
3.2.5 Consider need for collection of more detailed workforce information (para 29). (See also section 1.3–1.4 and Annex B of the planning guidance, January 2005.)	<p>Workforce Strategy Group</p> <p>Training and recruitment and collaborative group to identify and comment (see sections 1.7–1.8 and Appendices E and F of planning guidance, January 2005)</p> <p>Ditto</p> <p>Ditto and advertising agency</p>	<p>Workforce Strategy Group 22/1/04 agreed further workforce information and priorities as follows (public sector):</p> <p>Priority 1 – Vacancies, use of locums/agencies/bank staff and overtime.</p> <p>Priority 2 – Community profile comparison, existing levels of training of staff groups, current team structures and skills mix. Qualifications and experience to be defined.</p> <p>Priority 3 – Trends of recruitment, retention and vacancy rates for the current year.</p> <p>Exit interview information not yet available.</p> <p>Voluntary and independent sectors: Database of providers to be established. Write to providers requesting information. Follow-up data complete.</p>	<p>22/1/04</p> <p>Completed end of January 05</p> <p>Completed February 05</p> <p>Completed</p> <p>TBA</p> <p>Completed end of January 05</p> <p>April 05</p> <p>July 05</p>	<p>Collected workforce data. Updated 31/3/05.</p> <p>Training and development and collaborative groups and advertising agency to consider issues arising, including returners policy, grouping of training, training plan and joint training/secondment/ sponsorship and issues from meeting.</p> <p>Training and recruitment sub-group to identify and define relevant qualifications and experience, impact of KSF and consider draft.</p> <p>Refer to collaborative</p> <p>Data available. Training and recruitment and collaborative groups and service managers' groups to consider implications.</p> <p>Database established and questionnaire sent out week commencing 30/5 for 24/6 return.</p>

Action	Responsible officer	Milestones	Completion date	Current status/comments
<p>Stage 4</p> <p>Develop a strategic service plan and estimate workforce needed (pages 11–15 of the best practice guidance, paras 32–40)</p> <p>See also section 1.5 and Appendix C of planning guidance, January 2005</p> <p>4.1 Mental health strategy action plan:</p> <ul style="list-style-type: none"> • Establish virtual reference group. • Agree process for consultation. • Local need – meet with directors of public health. • Obtain mental health strategies work electronically. • Discuss with communications lead re. publication and communication. • Produce first draft for consultation. • Financial analysis by PCT/SSD/CWPNT. • Produce draft 1.1. • Review current commissioning/planning arrangements. • Final draft. • Consultation. • Launch of strategy. 	<p>Lead/Action Ms M</p> <p>Timescale By Oct 04</p> <p>Mr P</p>	<p>Finance mapping complete for AMH.</p>	<p>Completed . . .</p> <p>Completed . . .</p> <p>Completed . . .</p> <p>Completed . . .</p> <p>Completed . . .</p> <p>Completed . . .</p>	<p>Established mental health and learning disability exec enhanced commissioning capacity by est of deputy joint mental health collaborative and SHA collaborative commissioning group est.</p>
<p>4.2 LSSP (pages 11–12, paras 32–33).</p> <ul style="list-style-type: none"> • LIT to agree a dynamic LSSP to meet demand, which is reviewed and updated at three-yearly intervals and developed with stakeholders, service users and carers and which is used to estimate future workforce demand. <p>4.2.1 Review and update existing service plans (see stage 3).</p>	<p>Ms M and Ms P</p> <p>Ms M and Ms P</p>	<p>Draft three-year project plan/timetable, etc to group 22/11/04.</p> <p>Draft to LIT 11/11/04</p>	<p>Completed . . .</p> <p>Completed . . .</p> <p>Completed . . .</p>	<p>As per mental health strategy plan.</p>

Action	Responsible officer	Milestones	Completion date	Current status/comments
<p>4.2.2 Identify values and principles on which service will be developed.</p> <p>4.2.3 Develop an LSSP that identifies service components across primary, secondary and tertiary care (see 3.1.1).</p> <p>4.2.4 Decide demand to be met for each service component and location, clarify functions and inter-relationships.</p> <p>4.2.5 Plan to include features identified in para 12, page 33.</p>	<p>Ms M and Ms P</p> <p>Ms M and Ms P</p> <p>Ms M and Ms P</p>		<p>Draft completed</p> <p>July 05</p>	
<p>4.3 Estimate workforce needed. (page 13 para 34)</p> <ul style="list-style-type: none"> • Joint workforce plan produced as per details in paras 34–43 and guidance from National Workforce Programme, January 2005, including Annex D (see 5.1). 	<p>HR lead/SSD/service managers</p>			
<p>4.4 Skills mix (page 13, para 35)</p> <p>Include in workforce plan as per details in para 35.</p>	<p>Training and recruitment sub-group and collaborative groups</p>			<p>Group held 10/5/05.</p> <p>Refer to training sub-group and collaborative groups.</p>
<p>4.5 Context</p> <ul style="list-style-type: none"> • Joint workforce plan should take into account issues detailed in paras 36–40 and format in Annex D and planning guidance, January 2005. 	<p>As 4.2</p>	<p>Draft report June 2005</p>		

Action	Responsible officer	Milestones	Completion date	Current status/comments
<p>Stage 5 Implementation of joint workforce plan (pages 15–16, paras 41–43)</p>				First draft to WSG 20/7/05.
5.1	Plan produced as per Annex D format (and draft framework suggested by National Workforce Programme, January 2005). See 4.2.			
5.2	Services developed in co-ordination with workforce plan.			
5.3	Plan to include an action plan that identifies priorities and timescales agreed by all parties (see also Annex G of planning guidance, January 2005).	As 4.2 and service managers		
5.4	Plan to answer issues in page 15, para 41.	As 4.2		
5.5	Implement plan across agencies and organisations involved in service delivery.			
5.6	Involve consultation and collaboration with SHA, including data, as para 42.			
5.7	Link into workforce planning cycles with appropriate and timely information.	HR/SSD?		
5.8	LITs to provide progress report every three years to SHA.	Ms M		
5.9	Establish a feedback mechanism for those supplying information, as para 43.	As 4.2		

Action	Responsible officer	Milestones	Completion date	Current status/comments
<p>Stage 6 Cycle of review (Page 16, paras 44–45)</p> <p>6.1 Annual cycle of updating and evaluation by LIT.</p>			Autumn each year	Autumn review
6.2 Workforce planning to be tied into service planning and review.				
6.3 Three-yearly review of information analysis and workforce planning to be undertaken, as per para 45.	As 4.2 and service managers			

Second version

	Primary Care Trust	MH Trust	X County Council (CC)	Y Borough Council (BC)	Z Council	Action dates	By whom
Introduction – all						End of January	Mr W
Demographics and analysis of county-wide population and workforce – all						End of January	Mr O
Strategic priorities – all	LDPs JE ✓	✓ BG	Strategic priority for adult mental health for X CC	Strategic priority for Y BC ✓	Strategy Z Council	e-mail to Mr C by end of January	Mr W
Workforce plan data set 30/9/04 as distributed	✓	✓	Mr W By 11/4/05	Mr B Mr A	Mr A	End of Jan/ early February	
Data set narrative	✓	✓	Mr W By 11/4/05	Mr B Mr A	Mr A	February	
Service development	✓	✓	Partially completed (by 11/4/05)	✓ by 31/3/05	Ms E and Mrs W to meet with Ms C early April 05	Mid/late February	
Summary of common themes across the county – all					Ms W and Ms N	By sub-group meeting 6/5/05	
Knowledge and skills	<ul style="list-style-type: none"> • Nurses • Social workers • Support workers • Occupational therapist 	✓	✓	✓	✓	<ul style="list-style-type: none"> ✓ To be finalised by sub-group 6/5/05 	
Recruitment and retention – all	Mr W ✓	Ms N and Ms FA-H ✓	Mr W ✓	Mr A ✓	Ms H via Ms M ✓	To be finalised by sub-group by 6/5/05	
Action plan – all						Next meeting 10/5/05	All

Appendix K – Materials to support workforce planning

(These are not listed in any priority or ‘ranking’ order)

A Patient Centred Approach to Workforce Planning

Colloquially, this is known as the ‘Manchester’ Model. It is designed by the Manchester Centre for Healthcare Management at the University of Manchester.²⁵

County Durham and Tees Valley Workforce Development Confederation

Guide to Workforce Planning in Health and Social Care: May 2004
(helen.o’connor-pickering@cdiv-wdc.nhs.uk)

Department of Health

- *A workforce response to local delivery plans: A challenge for NHS Boards.*²⁶

National Workforce Projects

Following the development of a prototype, NWP has created a portal which hosts its work, as well as that of the Workforce Review Team (WRT). Sitting alongside this is a steadily expanding wealth of information from a range of organisations. Visit the website at www.healthcareworkforce.org.uk for:

- access to healthcare workforce planning information, knowledge, intelligence and skills development;
- the six-step guide to developing a workforce plan;
- an extensive portfolio of projects and a separate resource library;
- best practice examples;
- a wide range of downloadable reports and tools, together with audio files and resource packs, covering subjects such as the Working Time Directive 2009, long-term planning, modernising medical careers and the Social Care Minimum Dataset.

Sainsbury Centre for Mental Health and Middlesex University

- An MSc in Work Based Learning Studies (Workforce Development in Mental Health Services) is being introduced in collaboration between the Sainsbury Centre for Mental Health and Middlesex University. Contact malcolm.philip@scmh.org.uk for information.

Skills for Care (formerly TOPSS England)

- Workforce Planning Toolkit, 2nd edition (www.skillsforcare.org.uk).
- The Social Care Minimum Dataset was launched in April 2005 and provides a warehouse facility on social care workforce information. It is sponsored by TOPSS (now Skills for Care) England. Visit www.skillsforcare.org.uk for further information.

²⁵ Brooks, C and Bosma, T (2003) *A Patient Centred Approach to Workforce Planning*, The Manchester Centre for Health Management, University of Manchester.

²⁶ DH (2005) *A workforce response to local delivery plans: A challenge for NHS Boards*, DH, London.

Skills for Health

- Skills for Health has developed a labour market intelligence database to help identify the health sector's workforce needs. Visit www.skillsforhealth.org.uk
- Skills for Health and the NHS National Workforce Projects (NWP) have developed a (UK-wide) Workforce Planning Competence Framework. The Framework provides a suite of competencies that are necessary to carry out workforce planning to enable the delivery of safe and effective care to patients and the public. Visit www.healthcareworkforce.org.uk for more information. To complement the framework, NWP is exploring opportunities to use the competencies in delivering development programmes for those involved in workforce planning.

South West Peninsula Strategic Health Authority

- Local Delivery Plan Workforce Plan Toolkit: November 2004 (www.dcwdc.nhs.uk).
- Development of workforce plans: Joseph McEvoy, Workforce Lead – Mental Health: joseph.mcevoy@westprimcare.cornwall.nhs.uk

Appendix L – Glossary

A	advanced
A	assessment (test)
A4C	Agenda for Change
AF	application form
AMH	adult mental health
AMHP	approved mental health professional
ASW	approved social worker
BME	black and minority ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	cognitive behavioural therapy
CC	county council
CMHT	community mental health team
CPD	continuing professional/personal development
CSCI	Commission for Social Care Inspection
DC	development centre (of NIMHE)
DH	Department of Health
E&T	education and training
ECDL	European Computer Driving Licence
ESC	(Ten) Essential Shared Capabilities
ESR	electronic staff record
FTE	full-time equivalent
GCSE	General Certificate of School Education
HR	human resources
I	interview
IM&T	information management and technology
IT	information technology
IWL	Improving Working Lives
JWSU	joint workforce support unit
K	(a thousand)
KC	Knowledge Community
KIT	Keep In Touch
LA	local authority
LD	learning disability
LDP	local delivery plan
LIT	local implementation team
LNR	Leicestershire, Northamptonshire and Rutland (WDC)
LOS	length of service
LSSP	Local Strategic Service Plan
MDS	Minimum Data Set
MH	mental health
MHO	mental health officer (status)
NHS	National Health Service
NHSP	National Health Service Plan
NIMHE	National Institute for Mental Health in England
NOS	National Occupational Standards
NSF	National Service Framework
NVQ	National Vocational Qualifications
NWP	National Workforce Programme (of NIMHE)

OD	organisational development
OP	older people
OPMH	older people's mental health
OT	occupational therapist
PCGW	primary care graduate worker
PCT	primary care trust
PH	public health
PSS	Personal Social Services
RMA	Registered Managers Award
ROCR	Review of Central Returns
R,R&R	recruitment, retention and returners
SC	social care
SCMH	Sainsbury Centre for Mental Health
SEDC	South East Development Centre (of NIMHE)
SHA	strategic health authority
SLA	Service Level Agreement
SSD	social services department
SSP	strategic service plan
StLAR	Strategic Learning and Research Advisory Group
STR	support, time and recovery
SW	south west
TBC	to be confirmed
TOPSS	Training Organisation for Personal Social Services (now Skills for Care)
UK	United Kingdom
WAT	workforce action team
WDC	workforce development confederation
WDD	workforce development directorate
WPG	workforce planning group
WPPP	Workforce Planning Pilot Programme
WRT	workforce review team
WSG	workforce sub-group
WTE	whole-time equivalent



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