Department of Health

New Ways of Working for Everyone

A best practice implementation guide

Care Services Improvement Partnership CSIP

National Institute for Mental Health in England (NIMHE)

National Workforce Programme

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New Ways of Working for Everyone

A best practice implementation guide

October 2007

National Institute for Mental Health in England (NIMHE)
National Workforce Programme

Contents

1. Introduction

The purpose of this best practice implementation guide, produced by the National Institute for Mental Health in England (NIMHE) National Workforce Programme (NWP), is to set out how health and social care organisations could take a strategic approach to the implementation of New Ways of Working (NWW). Until now, NWW has been addressed by some practitioners and teams and has been discussed at Board level in some Trusts. In this guide, we aim to help and support organisations in addressing how NWW can be approached across the whole system. As NHS Trusts are the largest single employers of mental health professionals at this time, they have been identified here as the primary audience in the first instance.

A draft of this guide was presented to the NWW for Everyone national conference which took place on 25 April 2007, as well as the subsequent regional conferences organised by the Care Services Improvement Partnership (CSIP)/NIMHE development centres. It has been prepared with the help of feedback from a number of sources, including the conference delegates and those who responded to the call for comments set out on the NWW website at www.newwaysofworking.org.uk

2. What is the 'essence' of New Ways of Working?

A helpful way to understand NWW is to consider a mental health team from a traditional practice perspective and to compare it with a modern capability/competence-based team over a number of different parameters. Consider team A to be a mental health team, as will be found practising in many Mental Health Trusts, and team B to be a community mental health team (CMHT) adopting the principles of NWW. **It is important to say at this point that the teams described are stereotyped examples occupying extreme points on a spectrum. They are not intended to represent the typical position in any way, but to identify clear elements for the purpose of contrast and illustration.**

Leadership

Team A

Yes, the team has moved on since the days when the psychiatrist was seen as unquestionably the 'boss' of the team. There is a team manager and regular meetings, but in terms of leadership, there is an assumption that this is provided only by the psychiatrist, who, however, seems to be semi-detached from the team. They have lots of other responsibilities like ward rounds, clinics, emergencies and so on, and never seem to have enough time for the team meeting, which is squeezed between other important duties. No one has really thought through the issue of leadership within the team, whether it be in its generic sense or in terms of specific clinical leadership qualities. It's like the elephant in the room that no one comments on.

Team B

In its most general sense, leadership will depend on who is the most able and competent leader and who has the respect and trust of the team, irrespective of profession. Leadership may be rotated or shared, and the rest of the team collaborates in supporting the leader in decision making. A lead in clinical matters again depends on their competence, with each profession providing leadership in their area of expertise as appropriate. The psychologist may well lead on psychological therapies, but it could be the occupational therapist (OT), social worker or nurse; the psychiatrist may lead on pharmacological intervention, but that duty might be in collaboration with the pharmacist. The team is well established and assesses its competency mix, has distributed clinical responsibility and is becoming stronger as a result.

NWW point

Leadership within teams is complex but should be based primarily on competence rather than profession; there is healthy debate and collaboration rather than interdisciplinary conflict (often unspoken) and a focus on the team rather than on the individual professions. The team is stronger and more effective if it develops the competence of all its members rather than one or two professions dominating proceedings.

Team working and attitude

Team A

The consultant psychiatrist 'delegates' work to other team members but retains clinical responsibility for the patient, with great emphasis being placed on 'who carries the can'. The team feels obliged and under a degree of pressure to check regularly that clinical decision making is approved of, with marked feelings of subordination in a hierarchy. Non-medical members of the team may be quite happy to let the consultant psychiatrist shoulder all the responsibility. There may be a team atmosphere of concern and insecurity, with a fear of blame at getting things wrong.

Team B

Work and responsibility are distributed among the team based on individual members' competences. Team members are responsible for their own clinical decision making, with each working at a level of case complexity, with commensurate with their ability. The advanced practitioner works routinely with cases that have achieved some degree of pharmacological stability but may be able to work with more complex cases with the closer support of the psychiatrist and pharmacist. The psychologist, although specialising in psychotherapy with personality disorder, can work more effectively in collaboration with the psychiatrist and the crisis team.

There is a culture of realistic respect, collaboration and trust. This is underpinned by a sense that each member is working to support the other, robustly reviewed and with clinical concerns openly voiced and encouraged in the group setting.

NWW point

Good, modern, governance-driven, person-centred care requires distribution of responsibility, not delegation. Individuals are responsible themselves for the care they give, and no single individual is in charge of all clients on the caseload of the team. It is a natural and appropriate development for the most experienced and skilled clinicians of all professions to deal with people with the most complex needs and to support and develop the less experienced team members, thus building a more competent and capable team. The team culture should be towards each individual taking personal responsibility for the governance of their work in an atmosphere of openness.

Profession driven or user and carer focus

Team A

Care is delivered along profession-specific lines (psychiatrists deliver only biological interventions, social workers deliver social care and so on). The different professions meet at multidisciplinary meetings but it can feel like a patchwork. There is often a debate about what is the most appropriate approach for a particular case, and service users are put onto waiting lists for various forms of therapy. Some users and carers feel that the care is fragmented and that they are being fobbed off in order to manage demand on the team's time.

Team B

Care is delivered on a clear service user pathway by the most competent practitioner to provide it, regardless of profession. This allows a certain amount of skill blending, with professions other than medics carrying out prescribing duties and physical screening, and all professions delivering psychological interventions based on training and ability. By sharing some tasks and acquiring new skills, the team develops increasing capacity and a sense of pride in its capability. Users and carers feel that their individuality is being responded to and can engage more effectively with a team they can identify with.

NWW point

The best care is delivered by sharing the capabilities within a team and blending them to the needs of the individual service user. Few clinicians have a full hand of all the necessary skills, so assessment, care planning and co-ordination is about getting the blend right. Similarly, letting go of some practice to a common pool of team skills enhances what can be provided. The psychiatrist who helps to develop non-medical prescribing and the psychologist who trains and supervises people in cognitive behavioural therapy (CBT) benefit themselves, the team and the service user and carer in the longer term.

Innovation and efficiency

Team A

OK, times may have changed from when the psychiatrist had a personal caseload of 300 or more patients and no one could get an appointment for three months. However, they still hold four clinics a week and see a lot of patients individually, many of whom are quite stable and have been for some time. A number are also seeing a team member, and there is quite a lot of duplication of activity, with the service user having to attend an outpatient clinic, a community psychiatric nurse (CPN) appointment and a Care Programme Approach (CPA) meeting in the same week. There are also separate, long waiting lists for psychology.

Team B

All team members carry a similar number of cases based on capability and capacity. Consultants (regardless of profession) focus on the most complex, demanding and unstable cases, befitting their experience and skills. They are available to see other less complex cases when they need to be seen, but do not follow up the majority. Other team members carry and co-ordinate the care and seek an intervention from consultants when it is required.

There is levelling of caseload in the team and greater efficiency all round. The caseload is widely and evenly distributed, with an efficient and effective approach to the management of demand. Because one individual does not carry a disproportionate load, there is less likelihood of bottleneck development and obstruction to the care pathway.

NWW point

We can learn from industry here. Levelling of workload, multi-skilling the workforce and creating systems of flow create efficiency. A 'pull system', in which intervention is delivered 'just in time' based on need, is much more efficient than a 'push system', in which care is provided whether needed or not. Traditional outpatient clinics are based on 'push' – you attend whatever your need. A system of care co-ordination, in which intervention is organised when required, is more satisfying and relevant to the user, frees up time for the clinician who is not seeing those who are well, and provides better continuity of care. By spreading workload more evenly, demand is managed and there is less resistance from individual clinicians when asked to intervene. It works in industry and can be demonstrated to work in healthcare.

The intelligent use of information

Team A

The team gets on with the job of providing a service but it feels burdened by what seems to be ever-increasing demand. There rarely seem to be any discharges, and caseload mix is poorly monitored and regulated. There are tensions as some team members feel they are working harder than others, and the team manager has a difficult job to try to keep things running smoothly.

Team B

The team has a transparent and open caseload management system in place. There is regular supervision and discussion at team level as well as audit to ensure that there is effective balancing of caseloads based on competence and frequent challenge to members to consider what progress is occurring.

The consultant psychiatrist is challenged over their case mix, as is the psychologist and social worker, because this is seen as an exercise that encourages the intelligent use of information.

The team feels it knows what it is doing.

NWW point

It is better for the team to know the bigger picture rather than just to be closely engaged with clinical work. Scrutiny, supervision and challenge induce rigour into proceedings.

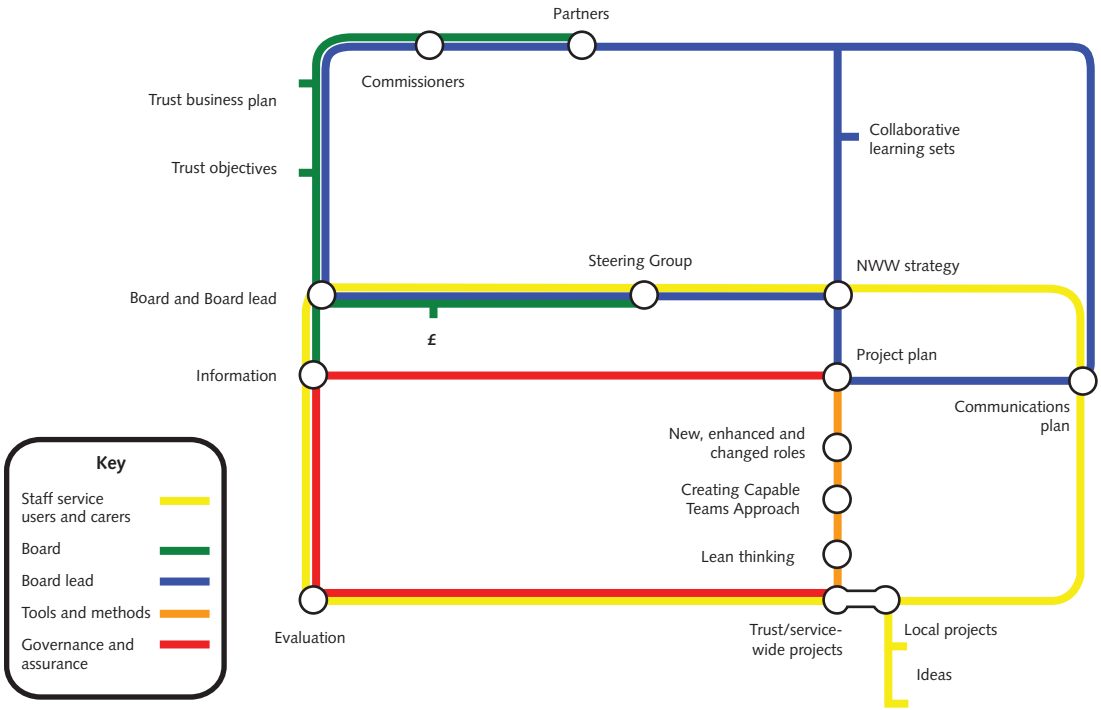
It does not help anyone, including users and carers, to be part of a system that is stagnant and cannot create clinical movement. The clinicians become cynical and disaffected (if not ill), and service users get stuck in the system.

In summary, then, achieving the maximum potential from a team requires a number of measures:

- clarity of leadership based not solely on profession but on ability and competence;
- a system of distribution of responsibility rather than delegation;
- a focus on the use of skills to match the needs of service users and carers;
- an attitude of individuals taking responsibility for clinical governance standards;
- the delivery of care through a team approach;
- attention to efficiency in the delivery of care, with the removal of waste and duplication; and
- effective and intelligent management of caseloads.

3. Local implementation: A whole-systems approach

Figure 1: Implementing NWW



Introduction of NWW should be part of a strategic approach, underpinned by the principles of person-centred values captured in the Ten Essential Shared Capabilities (ESC), and with full staff and service user and carer involvement and empowerment.

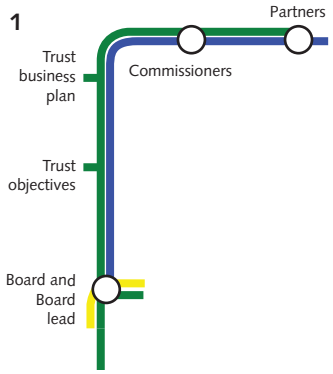
This will involve engaging with partners (in the statutory, voluntary and independent sectors) and commissioners.

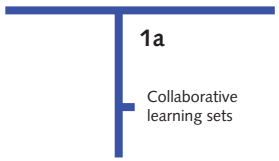
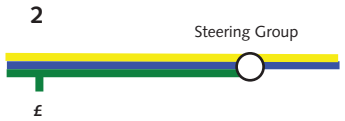
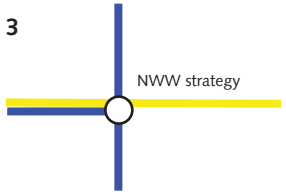
Experience suggests a way forward might be as depicted in section 4, of which the diagram above is a summary.

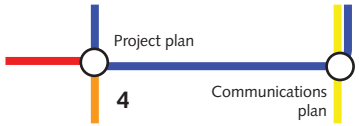
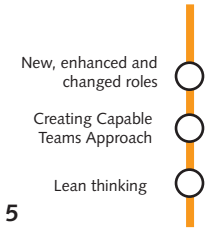
4. NWW action planning framework

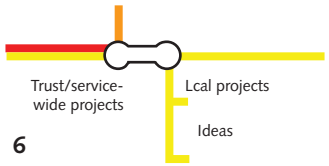
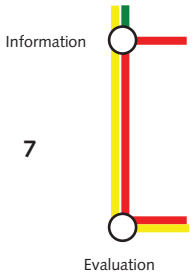
RAG=red, amber or green. Red – little or no progress; amber – progress on at least 50% of indicators and a recognition that all will be achieved by the deadline; green – fully achieved.

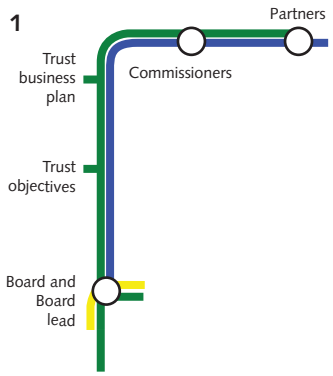
It should be noted that the table does not have to happen in a linear process, as some of the actions can/may happen in tandem.

Framework reference point	Potential steps	RAG	Your organisational milestones/notes
1 	1.1 Ensure that the Trust Board is aware of NWW and that there is a lead at Board level 1.2 Get Board agreement for the development of NWW in the organisation and its integration into organisational objectives 1.3 The Board should be conversant with the potential implications for: • service improvement; • consultant contracts; • benefits realisation; • changes expected within professional groups; • Agenda for Change (A4C); • service users and carers; and • learning and development		

Framework reference point	Potential steps	RAG	Your organisational milestones/notes
	1.4 Ensure that the Board is briefed on NWW progress nationally and internally and is aware of how it links with other areas of policy and development (e.g. *From values to action: The Chief Nursing Officer's review of mental health nursing*) 1.5 Ascertain ways of engaging commissioners on NWW and identify key partners 1.6 Identify two or three key leaders, to include the Board level NWW lead, to undertake the NWW for Everyone collaborative learning sets in 2007/08 1.7 Agree resourcing for the development of NWW (e.g. adequate time and other resources for Board lead role, service user and carer involvement, project management, data analysis, training and development)		
	2.1 Establish a NWW Steering Group comprising key clinical leaders from all the professions, management leads, staff-side representatives, service users and carers, ensuring that service provision, learning and development are all represented 2.2 The Steering Group will develop the strategy, project and communications plans, and oversee the development and implementation of Trust-wide and local projects		
	Develop and adopt a NWW strategy, which: 3.1 is linked to the organisation's business plan, financial plan and workforce strategy; 3.2 is linked to a learning and development strategy; 3.3 includes endorsement of policy on professional roles and responsibilities (e.g. based on Avon and Wiltshire guidance in the NWW Interim Report, expanded for all staff groups); 3.4 explicitly includes the role of trainee staff; 3.5 is endorsed by commissioners and all stakeholders; and 3.6 brings all aspects of NWW together to create your vision for an effective, efficient workforce delivering person-centred care		

Framework reference point	Potential steps	RAG	Your organisational milestones/notes
	4.1 Establish NWW as a project, with a project plan and milestones 4.2 Develop a two-way communications plan which includes engagement of staff, trades unions, service users and carers, commissioners and partners 4.3 For each group and team, arrange meetings to explain what NWW is all about, how they can be involved and what they could already be doing 4.4 Ensure that strategy development is informed by the views of staff, service users and carers, and that an ongoing communication process is developed – this may include newsletters, presentations, etc. 4.5 The project plan needs to describe how key corporate departments will be involved in the project, including human resources (HR), finance and performance. HR has a key role, and it is essential that other corporate functions understand and support the aims of NWW in order for it to succeed		
	5.1 Ensure that the strategy explores the potential for all aspects of NWW, including: • changing the roles of the existing workforce; • enhancing the roles of the existing workforce; and • bringing new people into the workforce in new roles 5.2 Explore how the elements listed in 5.1 above can be addressed within a multidisciplinary team (MDT). CSIP has developed the Creating Capable Teams Approach (CCTA) as a tool to support NWW at team level. Ensure that your organisation has identified people to attend one of the training workshops for facilitators, and that use of the tool is part of the organisation's workforce and organisational development strategies, linking with the NWW strategy 5.3 Redesign processes to improve efficiency and maximise support to staff in their roles. The principles of lean thinking, which is about maximising value and reducing waste, could help to support this		

Framework reference point	Potential steps	RAG	Your organisational milestones/notes
	5.4 Underpin the process with competences, rather than professional numbers, reflected in job descriptions where appropriate. CCTA will help to examine the skills and competences required to meet the needs of the populations served by the teams, and this can lead to more flexibility in team composition, rather than a rigid adherence to a model where certain professions have to have a particular level of representation. However, the process also recognises that there are skills and competences that are more specific to individual professions. Teams need to consider whether they need to bring in new skills they have not had access to before, such as the input of a mental health pharmacist. Services need to work closely with HR in the development of NWW job descriptions, to anticipate and deal with difficulties or grievances arising from A4C bandings, etc. 5.5 All the above can be linked to developments in flexible and home working, technology, and environmental sustainability		
	6.1 Identify, within the overall project plan, the individual project streams. Some projects will affect the whole organisation or service, others will be more local 6.2 Identify enthusiasts – incorporate existing local projects into the overall project plan. Use enthusiasts for further implementation and to disseminate results 6.3 Develop a culture where creativity is celebrated and bottom-up innovation is encouraged and incorporated		
	7.1 Review progress of individual projects and implementation of the strategy as a whole against locally agreed timescales and milestones 7.2 Evaluate projects against success criteria which have been jointly developed by staff, service users and carers. This will form your assurance to the Board and other stakeholders 7.3 Over time, develop service and performance standards for NWW 7.4 Identify examples of innovative/best practice; disseminate and share this across the Trust and with commissioners and staff		

Framework reference point	Potential steps	RAG	Your organisational milestones/notes
	7.5 Make regular progress reports to the Board 7.6 Store good practice information, evaluation data and lessons learned on the NWW website at www.newwaysofworking.org.uk		
1 	8.1 Expect the process to take five years overall and plan annual reviews and regular updates to the Board, the organisation, members of staff, service users and carers		

Additional notes/steps for your organisation

5. How do you know what NWW looks like when you have got there?

It can be difficult to visualise what NWW might look like and mean for everyone. The table below sets out some indicators and outcomes that help you demonstrate what NWW will look like when it is in place. Discussions are taking place with the Healthcare Commission about how NWW might be incorporated into the standards they use to measure progress in mental health services.

Indicators and outcomes that help demonstrate what NWW will look like when it is in place

Indicator	Organisation's position (red/amber/green)	What you might expect to see as a result	Organisation's position (red/amber/green)
Organisation			
Board has discussed: • NWW for Psychiatrists Final Report 2005; and • NWW for Everyone Progress Report 2007		Organisation has an NWW strategy and operational programme	
		Board policies on roles, responsibilities and accountability of clinical and non-professionally affiliated staff are in place Job adverts promote options for different professions to apply for positions based on capabilities and competences	
		NWW covered explicitly in annual reports, business plans and minutes of Board meetings	
Nominated NWW lead at Board level		Regular updates to Board on progress with NWW	
Joint guidance on employment of consultant psychiatrists embedded in Trust HR policy		Job descriptions for consultants not primarily based on catchment areas; content of jobs defined by robust job planning	
Explicit link between service improvement plans and workforce strategy		Workforce and NWW more explicitly embedded as part of core business	
Robust workforce strategy for the organisation in place, citing skills and competences required		Organisation workforce budget is in balance Gaps no longer expressed solely in (traditional) staff numbers	
Training strategy explicitly linked to workforce strategy		Improved use of training resources and contracts with higher education institutions (HEIs)	

Indicator	Organisation's position (red/amber/green)	What you might expect to see as a result	Organisation's position (red/amber/green)
Use of temporary staffing		Use of internal bank staff for all professions in place and effective use being made of NHS Professionals where external agencies are required Temporary staff specifically planned for	
Monitoring of vacancies		Vacancies are used as an opportunity for role and system redesign and consideration of appropriate skill mix based on use of CCTA principles	
Staff turnover		Improved retention year on year Reduced costs of recruitment	
Serious untoward incident data		Reduced levels of serious incidents; reduced number of recommendations relating to (poor) skills and competences and co-ordination	
Policy on risk		Policy on risk includes positive risk taking	
General rather than solely professional management arrangements in place		Corporate as well as professional accountability explicit	
Senior clinical staff of all professions involved in policy development		Annual improvements in ratings in staff survey	
From values to action: The Chief Nursing Officer's review of mental health nursing disseminated, assessed and implemented		Mental health nurses have acquired the skills and support to provide holistic and effective person-centred care to service users, many working in new roles and new ways	
Information technology (IT) available to support flexible working – computers, BlackBerries, laptops, video or telephone conferencing, mobile telephones		Annual improvements in staff survey results Annual improvements in sickness levels Year-on-year reductions in travel costs	
Teams			
Teams within the organisation have individual workforce plans based on CCTA principles and process		Teams have devolved, balanced budgets and the flexibility to use them on a case-by-case basis	
Caseload monitoring		Clarity on size and mix of caseload, taking a team approach to referrals	

Indicator	Organisation's position (red/amber/green)	What you might expect to see as a result	Organisation's position (red/amber/green)
CCTA in regular use for learning and development review		Teams describe their competences and capabilities to meet service user and carer need	
Areas of competence addressed to include: • medical; • medicines management; • physical; • psychological; and • social (inclusion)		A team with the appropriate knowledge and skills spread among team members, regardless of professional labels or badges A more holistic approach to care and treatment for service users and carers	
A well-balanced skill mix		Creative solutions to meeting service user and carer needs (whole-systems approach) Improved levels of service user satisfaction Teams have a range of new or extended roles, including support, time and recovery (STR) workers, non-medical prescribers, staff delivering psychological interventions, supporting people back/into employment, etc., based on need and purpose of service	
Team leadership		Multidisciplinary teams operate dispersed leadership based on appropriateness of capabilities of team members	
Team management		There is a designated team manager for operational purposes	
Teams collect and use own data to improve performance		Reduced levels of drug errors Improved levels of complaints Reduced waiting lists for treatment High service user and carer satisfaction with service Clarity of effectiveness of interventions	
Trainees are an integrated part of the team		Effective use of all the available workforce Relevant learning, development and supervision provided for students for future roles	

Indicator	Organisation's position (red/amber/green)	What you might expect to see as a result	Organisation's position (red/amber/green)
Staff			
Accountability and responsibility		Staff are clear about and confident with their roles, responsibilities and accountability as part of a distributed responsibility model Positive response to staff surveys	
Career progression		Internal promotion within and between professions	
Annual appraisals		Clear sign-up by staff to service user- and carer-centred values. NWW issues and the Ten ESC addressed Staff can explain how NWW impacts on them and their team	
Audits of working practice completed and used to drive NWW		All consultant and other senior professional staff with smaller caseloads have additional responsibility of supervising and supporting staff, learning and development, research, service improvement, etc.	
Learning and development			
Training needs analysis		Learning and development linked to needs and priorities of service users and carers, underpinned by effective multidisciplinary working	
		Costs of learning and development and continuing professional/personal development (CPD) optimised HEIs undertake and support work-based, competence-based learning	
Organisation's learning and development priorities underpinned by explicit values		The Ten ESC included in staff induction programme and CPD	
CPD focuses on extending practice		Non-professionally affiliated staff, as well as those who are professionally qualified, recognised as having key development needs	
		Existing skills within teams used to develop other team members in the workplace	

Indicator	Organisation's position (red/amber/green)	What you might expect to see as a result	Organisation's position (red/amber/green)
Variety of informal and formal training methods used		Clear evidence to show that service users and carers are involved in learning and development, e.g. planning, delivery and evaluation	
Team learning and development includes the needs of trainees		Trainee psychiatrists, psychologists, nurses, social workers, allied health professionals and others are adequately prepared for NWW	
Service users and carers			
Service users and carers are represented at all levels of the organisation		Evidence of effective partnership working Copies of minutes of meetings show service user and carer representation and attendance	
Service users and carers employed in organisation and systems in place to support them		A more representative workforce is in evidence Experience of being a service user or carer is a desirable criterion in person specifications for jobs Explicit service user support policy document published to include allocation of appropriate resources	
CCTA		Clear evidence of service users' and carers' participation	
Outpatient appointments are needs led		Service user and carer experience more focused; service co-ordinated and appropriate to their needs	
Care plans reflect whole person needs		CPA care plans show continuing positive outcomes Evidence of service user participation in CPA process	
Surveys		Positive response to service user and carer surveys	
Care pathways designed based on service user and carer needs and linked to staff skills		Evidence of local gathering of data on service user and carer satisfaction	

6. Frequently asked questions

1. New Ways of Working – what is it all about?

1.1 What is New Ways of Working?

New Ways of Working (NWW) is about a **new way of thinking** which includes the development of new, enhanced and changed roles for mental health staff, and the redesigning of systems and processes to support staff to deliver effective, person-centred care in a way that is personally, financially and organisationally sustainable.

Examples of new roles include STR workers, community development workers (CDWs) for black and minority ethnic (BME) communities, graduate mental health workers and a variety of assistant practitioner and mental health worker roles. Professionals from a variety of backgrounds are training to enhance their skills, for example in non-medical prescribing, physical health assessment and psychological therapies. They are also changing the way they work to ensure that it provides the most benefit to service users and carers. For example, this involves consultant psychiatrists seeing people when needed rather than routinely, and working directly with a smaller number of the most complex cases while providing advice and consultancy support to team members, primary care and other partners on a larger scale.

NWW is a cultural shift – it involves rethinking values, ways of working and roles to deliver person-centred care.

1.2 Is it really 'new' at all?

There have always been organisations which have developed new roles, staff who have sought additional training, and team members who have worked together to optimise their functioning individually and as a unit in the service of their clients. However, it is equally true that in many places traditional models of service delivery persist which do not match service user and carer needs or organisational expectations. NWW is a way of systematising and mainstreaming innovative and forward-looking approaches, and of disseminating and developing good practice that has come from the bottom up, from practitioners who have seen opportunities to improve the service they provide.

1.3 Where has NWW come from?

NWW has been around for some years, but got particular impetus in mental health in 2003. This is when two national conferences for consultant psychiatrists summarised what they saw as the problems in their profession – significant difficulties recruiting and retaining psychiatrists because of the increasing demands of the role, increasing degrees of burnout among consultants, unsustainably high caseloads and crippling expenditure on agency locum doctors to try and plug the gaps. When these problems were examined, it quickly became apparent that because consultant psychiatrists were part of a system, and other parts of that system were demonstrating the same stresses (demonstrated, for example, in a study of social workers), all the parts of that system needed to be considered in order to effect change and produce sustainable jobs for all.

1.4 Who is NWW for?

Everyone: i.e. people working in mental health, in whatever care setting they are based, and the service users and carers they work with. Since 2005, national groups representing all the different allied health profession (AHP) staff, including OTs, applied psychologists, social workers, nurses, pharmacists, psychiatrists, primary care staff and non-professionally affiliated workers, have all been addressing their own particular NWW issues with support from colleagues in the other disciplines and from service users and carers. This work has now resulted in a set of common and specific themes which all groups want to take forward in a multidisciplinary forum. These can be found on the NWW website at www.newwaysofworking.org.uk

1.5 Why is NWW necessary?

Back in 2003, NWW was necessary to help solve the difficulties being faced by the psychiatrists, as outlined above. Together, with other levers for change such as the new consultant contract, NWW has contributed to a significant improvement in vacancy rates and the development of fulfilling, sustainable jobs providing effective care. However, reform and regulation, the drive towards Foundation Trust status and, most importantly, the rising expectations of service users, carers and the general public have all focused larger lenses on mental health services now than ever before. This has demonstrated that services need to be more flexible and person centred, at the same time as providing demonstrable value for money, in order to be sustainable. This requires organisations to analyse what skills they need in their teams, and to create capable teams with effective leadership supported by efficient processes and infrastructure. NWW aims to provide tools to help achieve this and the communication necessary to disseminate learning about new approaches.

1.6 Where is NWW happening and how can I find out about it?

Reading the New Ways of Working for Everyone Progress Report (2007) will help to bring you up to date, and the Final Report on New Ways of Working for Psychiatrists (2005) also provides a wealth of information. These can be found on the NWW website (www.newwaysofworking.org.uk). All the professional bodies and key stakeholders who have supported the initiative from the beginning will be posting their workstream products, guidance and positive practice examples there. The workforce leads in the regional development centres (RDCs) of CSIP also have a good overview of the state of NWW in their areas; some have commissioned regular progress reports which are available. Medical directors are linked in to the national programme via the Royal College of Psychiatrists Medical Directors network, as many have the role of Board champion for NWW in their Trusts on behalf of all staff. Some Trusts have now employed NWW leads to co-ordinate and manage implementation of NWW.

2. Where does the support for New Ways of Working come from?

2.1 Is NWW a government policy and will it be replaced by some other initiative soon?

The strength of NWW is that it has been developed by practitioners themselves, by those working on the front line who saw that roles, systems and processes needed to change to be able to cope with today's and tomorrow's expectations. This bottom-up innovation has been supported throughout by a national strategy, as evidenced by the support for projects from the Modernisation Agency and the Changing Workforce Programme, and then the NIMHE NWP.

NWW is about a hearts and minds cultural change, about considering ways of working from a person-centred, values-based standpoint and about developing services – and roles within them – which are flexible and responsive. NWW isn't complicated: much of it is common sense, and many NWW changes can be easily and simply made. As such, it should just become the accepted approach to doing things because it makes sense.

2.2 Is NWW supported by my professional body/trade union?

The National Steering Group on NWW, and the work it has commissioned including all its reports, have been supported by the professional bodies and trades unions that represent workers in the mental health field. NWW is also aligned with the objectives of the regulatory bodies.

2.3 Is NWW supported by my Trust?

If you are not sure about the answer to this question, ask them! Our data gathered from Trusts in England, summarised in the NWW for Everyone Progress Report (2007), indicates that the majority have discussed the Final Report on New Ways of Working (2005) at senior level, and that their 'average team member' will have heard about NWW. However, actual NWW initiatives can be patchily distributed within organisations, and we are not yet at the stage where any could say that they have comprehensively introduced NWW throughout the organisation – so there is still plenty of work to do.

2.4 What support and assistance will there be at national level?

The NWW programme has been co-ordinated by the NIMHE NWP, now part of CSIP, and a small team is continuing work in 2007/08. The NWW programme is overseen by the NWW National Steering Group, representing all of the professional bodies, organisations and key stakeholders, including service users and carers. It will continue to provide oversight and guidance at a national co-ordinating level, and there will be a National Operational Group that will focus on implementation issues.

2.5 What support and assistance will there be at regional and local levels?

The vision is that at a regional/local level, the NIMHE/CSIP RDCs, working closely with Strategic Health Authorities (SHAs), commissioners and NHS Trusts, will take the lead. They will do this by continuing to spread the message about NWW, identifying good practice (for example by hosting a conference on NWW), inserting details on the NWW website at www.newwaysofworking.org.uk, articulating this to all stakeholders and providing the immediate support so that all mental health providers, across health and social care, will fully implement NWW. The precise form this will take depends on local circumstances. Specifically, however, the intention is:

- through collaboration between the College Research Unit/Centre for Education and Training of the Royal College of Psychiatrists and the NIMHE NWP to run a series of collaborative NWW for Everyone learning sets for director level and senior staff (multidisciplinary) within Mental Health Trusts (one per SHA). The purpose will be to accelerate the implementation of NWW countrywide, with the learning to be collected and distributed via the NWW website; and
- to run workshops for facilitators of the CCTA in each region, with follow-up network meetings to support and collect feedback on CCTA and the implementation of NWW at a team level.

3. What are the concerns about New Ways of Working?

3.1 Is NWW about cutting costs or dumbing down?

No, it is about using people's skills to the greatest effect, where and when they are needed. It is about working supportively in teams. Cost and skill mix reviews have been a fact of life for a long time and will continue to be so; NWW offers opportunities for not only surviving such reviews, but making positive changes in practice to develop a more efficient service.

3.2 Is NWW about having specialist inpatient consultant psychiatrists, or cutting the number of consultant psychiatrists and other highly paid staff?

There is no single way to develop NWW. Specialist, inpatient consultant psychiatrists, or consultant psychiatrists working across the acute care pathway in crisis and inpatient work, are an example of NWW, and just over a third of Trusts have developed these roles, the so-called 'functional model', in at least part of their area. Where they have been implemented, they have been very successful, with demonstrable improvements in the inpatient experience for service users, carers and staff. The trick, then, is to ensure continuity with the community services that will always provide the bulk of care for individuals.

NWW is not about cutting the number of consultant psychiatrists; indeed, there has been a large expansion in the number of consultant psychiatrist posts in recent years. The same is true of psychology. This is unlikely to continue, however, and with an ageing population and significant numbers of staff approaching retirement, alternative ways to meet the continuing rise in expectations and demand have to be developed which involve NWW. In addition, there is more pressure on costs, and staff, therefore, have to be used most effectively to provide value for money. All consultant practitioners will have to prove they are worth the investment made in them, and they will need to be flexible and adaptable in their roles in order to achieve this.

3.3 How does NWW link to Improving Access to Psychological Therapies (IAPT)?

Quite easily. There is a need to develop interventions for people with depression and anxiety at two main levels – steps 2 and 3 as in the National Institute for Health and Clinical Excellence (NICE) guidance. This translates into i) staff delivering low-intensity interventions (bands 4–6), which will bring new people into the workforce at assistant and practitioner levels; and ii) staff delivering high-intensity interventions, which will include existing staff extending their roles (for example, OTs and nurses training to be CBT therapists), with the most senior staff, usually at consultant level and mainly psychologists and psychotherapists, dealing with people with more complex needs and supervising other staff at all levels.

4. What are the risks of New Ways of Working, and what problems can arise?

4.1 Is there a risk of loss of professional identity and role erosion, and 'genericisation'?

This risk is more likely to be perceived by professions who are either 'giving up' certain roles or tasks, or where those roles and tasks can now be performed by a wider variety of people. The prime example here is psychiatry. Non-medics can now prescribe independently and in collaboration with a psychiatrist; the clinical leadership of a team is no longer seen as part of the consultant psychiatrist's role by right, and the role of the Responsible Medical Officer will be replaced by that of Responsible Clinician in the Mental Health Act 2007.

Psychiatrists needs to respond to these challenges, some but not all of which are related to NWW, not by trying to find a 'unique selling point', but by emphasising the development of a broad range of skills based on a firm knowledge and evidence base during psychiatric training, together with a depth of understanding. If the functioning of teams in future is to be based on capabilities, then psychiatrists must have the range of integrated capabilities to offer which make them a valuable part of any team, and an essential part of many.

Training, which includes the development of leadership skills and values-based practice, a degree of technological and managerial competence and the ability to understand and work in complex systems, will produce psychiatrists for whom NWW is the natural way of working, and who also approach their work with flexibility and expect to have to develop new skills throughout their careers.

There is a concern that as the role of consultant psychiatrist changes, training opportunities may be compromised. Leaders, including the Royal College of Psychiatrists, CSIP and the Psychiatric Trainees Committee, need to work together to develop a framework for training which ensures that, instead, the opportunities of NWW for trainees, while training and as future consultants, are realised.

Members of some professions may feel that by taking on extended roles, colleagues are losing their traditional focus and outlook, and that they might perhaps be 'infected' with the 'medical model', but NWW is about enhancing and broadening capabilities, not substituting them. Social workers in an integrated Trust and MDT should be major culture carriers for a socially inclusive perspective and be valued and value themselves for this. A good medical model is holistic just like a good social or psychological model, so perhaps the time has come to ditch some of the old ways of thinking and describe what we are really aiming to achieve in terms of values-based,

person-centred care (necessary, but not sufficient, for high-quality mental health provision). An effective team shares work, demonstrates flexibility while having a clear understanding of and value for the individual professional contribution; all professions should see themselves as integral members of an MDTon this basis. This has been agreed for psychologists from the NWW for Applied Psychologists workstream.

The genericisation debate pre-dated NWW and is also linked to concerns about, for example, the extent of the role of the care co-ordinator; it is recognised that there has not been sufficient guidance on this in the past, and clarification of the role and the competences it requires are part of the CPA national review, with which NWW is linked.

An example of where a team has embraced taking on the roles of other members of the team to ensure continuity of involvement from a single worker can be found on the NWW website – see the Croydon Memory Clinic case study.

4.2 What are the problems around responsibility and authority?

In some ways, this is the obverse of the concerns about loss of professional identity. NWW explicitly endorses a model of distributed responsibility, with practitioners being responsible for the care, treatment or advice they provide, but not for that provided by others. This means that extended roles will carry more responsibilities – if an untoward incident befalls a service user with whom the consultant psychiatrist is not involved, that consultant psychiatrist would not expect to be involved in the investigation afterwards, except in providing appropriate support to colleagues. It also means that practitioners must have the requisite authority to carry out their roles – for example, if a request from a non-medical prescriber is queried because it does not come from a doctor, this should always be challenged, otherwise the culture will not change.

4.3 Won't NWW increase clinical risk?

NWW has to be underpinned by a culture shift. If working practices are changed by diktat without that underlying shift in culture and attitude having taken place, both active and passive resistance will sabotage the project. Hearts and minds need to be won to a point where there are shared objectives, active collaboration in the project, enthusiasm, and encouragement of constructive criticism and challenge. The involvement of service users and carers from the beginning is a key way to help this happen. It is very easy, perhaps especially so in mental health, to oppose change by raising the spectre of risk, and by asking for 'evidence' that cannot possibly be provided to the standards demanded.

NWW is not about replacing people who can do a particular task with people who can't; therefore it is not about increasing risk. It is about ensuring that everyone working in services is appropriately skilled to do the tasks required of them and that suitable supervision and support are in place for all, irrespective of their seniority. There are many ways in which clinical risk can be reduced by NWW, for example by having more people in the team with a greater awareness of physical health problems and the potential side effects of medication; more people in the team skilled in initial assessment, and risk assessment which is carried out by pairs of professionals; a consistent consultant presence; and leadership on the inpatient unit. These are all examples of NWW which have as one of their aims improving safety and reducing risk.

When people (usually staff) are concerned about increasing clinical risk, it also has to be remembered that the status quo is not a risk-free option, and that NWW is not change for change's sake, but a method of service improvement.

4.4 What are the risks when there is a lack of clarity of purpose or scope?

If the strategy for NWW in an organisation is not clearly articulated, the projects that come under the NWW banner will also not be clear in their purpose or scope, and this will make them harder to complete successfully and will reduce the opportunities for cross-organisational learning. It is always worthwhile taking the time to really think about what the project is designed to achieve and how this meshes with the overall objectives of the organisation. Utilising project management skills, which clinicians often do not have but which can be found elsewhere in the organisation, will help to keep things on track.

4.5 What are the risks of inadequately resourcing the change process?

It is important that when the Board endorses a vision and strategy for NWW, it understands that service redesign projects require appropriate resourcing if they are to be effective. This may mean freeing up sufficient staff time and having the resources to engage and include service users and carers. This may include paying them for their time; money for elements of the communications plan such as meetings, away days or documents; sufficient administrative support for a project; or bringing in people with particular skills, for example project management, information management or business analysis. The resource will clearly depend on the size, complexity and anticipated duration of the project, and those establishing projects and bidding for resources should be advised as to the best way of thinking about the benefits realisation the project will bring. Organisations should also seek to develop knowledge and expertise in applying for sources of external funding for pilot projects of various sorts.

4.6 What are the risks of lack of leadership and support?

The proposal for a Board-level lead for NWW in an organisation is made so that Trusts can demonstrate their commitment to NWW in this tangible way, and also to give a focus for the activity within the Trust so that it is co-ordinated, and so that the appropriate learning and evaluation takes place. It is not designed to mean that NWW should be 'top-down' – the lead's job will be to ensure that the bottom-up creativity and enthusiasm for local projects are harnessed to the objectives of the organisation as a whole.

4.7 What are the risks when personal development is not aligned with organisational objectives?

Many Trusts will be able to identify examples where particular training courses have been available, and staff have signed up for them and completed them but then not been able to use the new skills they have acquired. This happens when training is simply something that the individual member of staff considers as part of CPD, rather than it being part of the overall workforce and linked learning and development strategy. This inability to practise what they have learnt is very frustrating for staff and a waste of finite resources.

4.8 What are the risks when changes are made in parts of a system and the rest does not adapt?

This risk is related to the one above. In this case, the workforce strategy may include, for example, the recruitment of new types of worker, such as the STR worker, or the promotion of psychosocial interventions (PSI); however, there has been no detailed thinking done about how the new workers, or the staff with new skills, will be able to work within the team (or how they will be appropriately supervised), because there has been no thought given to the whole team having to change the way work is distributed. This requires planning before courses or recruitment take place, so that the person can slot into the role expected of them and has time to do so. Also, the rest of the team must be clear about what the role is and how the skills the person brings will be used, as well as, crucially, any other work that will need to be redistributed.

5. How am I affected by New Ways of Working and how can I help it develop?

5.1 How does NWW affect me as a service user, and as a carer?

If NWW is embedded in the team(s) you link with, you should find that they are flexible and responsive to your needs. Most teams will have a focus on recovery; for some working with different client groups the emphasis will be on rehabilitation and

living as valued a life as possible; or, at the end of life, for some a palliative care approach with care and support for patients and their families will be appropriate. The team will be always be looking for ways to improve and will involve service users and carers in that process. Your experience of services may change; for example, you may find that your needs can be met by fewer people, because some staff in the team have acquired additional skills (e.g. in prescribing). You should find it easier to get access to those with the appropriate skills to help you if you become more unwell. You should find yourself reassured and informed and fully part of, not intimidated by, the care planning process. The team will communicate well with you – perhaps offering a variety of methods – and with your general practitioner (GP), and they will be open about sharing information and collect it appropriately. You may find that some aspects of your care can be provided in a primary care setting. If you need to go into hospital you should find that, although different people may care for you, your care co-ordinator ensures continuity and plans with you and your ward team for your discharge from the point of admission, involving your carers at each step.

If the providers of your services have embraced NWW there should be some information about it; nationally, leaflets will be produced to highlight the main features and indicate how to get local information.

Your team, and the organisation of which it is part, will be working towards the inclusion and involvement of service users and carers in service development and evaluation as the norm. Programmes such as the CCTA will help to embed this change, by emphasising the active participation of service users and carers throughout. Trust policies will demonstrate that the practical issues (e.g. expenses, transport and communication) have been thought through.

5.2 How does NWW affect me as a practitioner?

NWW emphasises the collaboration of all practitioners within teams to achieve person-centred care for service users and carers. However, within this, as an individual practitioner you will want to review the way you work, to ensure that it is efficient and uses your skills appropriately. You may feel anxious about what might be expected of you but you will have ideas not only about your own practice but also about how the whole team can improve, and it is this bottom-up innovation that will enable your team to develop NWW effectively.

5.3 How does NWW affect us as a team, and what can I do about it as a team manager?

The first step is to look at how the team is organised: is there a model of distributed responsibility, with all members taking responsibility for the care they provide? If you are a CMHT, for any age group, have you moved away from any notion of the

consultant psychiatrist being 'in charge' of all the 'cases'? If you are a ward team, are ward reviews truly multidisciplinary, with contributions from all equally valued? What can you do about your team processes, to make them more efficient and reduce duplication and wasted time? Have you looked at the roles of everyone in the team, to ensure that their skills are being used to best effect? What do your service users and carers think? Can you put forward team members for additional training with a clear idea of how you will all utilise the new skills they will bring? Does the team look at its own performance data? You will want to read the CCTA documentation to help you to develop a team competence model or look at the prompt questions in Section 7 of this guide.

5.4 What can I do about NWW as a director?

You should help to ensure that your organisation can affirmatively answer questions like:

- Does your workforce strategy consider the potential for developing or expanding new types of role in your workforce using existing staff more effectively, and is there a plan for delivering this?
- Is there a strategic approach to developing enhanced skills in the workforce, so that the right people are trained, and so that their roles and those of the teams they work with are then adapted to allow them to use their new skills?
- Is NWW discussed in your integrated business plan, and do your commissioners understand its potential?
- Do you have assurance that you are using your workforce, particularly the most expensive elements of it, in the most effective and efficient manner? How prevalent is job planning and appraisal, and do they consider the person in the context of their team?
- Do you know which teams are having the most difficulty managing their workloads, and is the organisation doing something about it?
- Is there a strategy for dealing with a consultant psychiatrist vacancy that involves more than automatic recruitment of a locum and then a straight replacement?
- How efficient are your clinical and administrative processes? Can you demonstrate that you are achieving the 10 High Impact Changes for Mental Health?
- Are there mechanisms for involving service users and carers and frontline staff in generating ideas for improvement, and is the infrastructure there to support implementation if so?

5.5 What do I need to know about NWW as a commissioner?

The core of a mental health service is its staff, and those staff can be developed in three ways: existing staff can work differently; existing staff can be trained in additional skills, beyond their traditional scope of practice; and different roles can be developed to bring new people into the workforce. These staff can then form capable teams if they are deployed within a service model attuned to the needs of its users and carers, supported by good systems (particularly information systems) and adequate resources, and embedded within a values-driven organisational culture with leadership and effective team working modelled at all levels. As a commissioner you will want to know that all these elements of NWW are being developed in the organisations that provide your services, because they are at the core of a sustainable enterprise that provides quality, value for money and choice for your population.

5.6 Do others, for example the public, GPs and coroners, know about NWW?

The amount of knowledge is variable, and it is vital for us all to seek to explain the concepts and therefore increase it. People are perhaps more used to NWW in other branches of the health service, such as emergency care practitioners, new roles in primary care, chronic disease management and even surgery, so it just needs explaining that things are changing in mental health too. The primary care subgroup of the National Steering Group on NWW is actively promoting NWW in mental health across care settings and helping to raise awareness. We are seeking to develop a guidance document with the Coroner's Society for England and Wales to explain what the changes might mean for them and their work, which will incorporate the new roles in the Mental Health Act 2007.

6. New Ways of Working and the national context

6.1 Is there a link between NWW and Foundation Trust status?

All Mental Health Trusts in England are established or aspiring Foundation Trusts and, as such, they must demonstrate not only that they can break even, but that they are sustainable organisations which can generate surpluses. Since most spend about 70% of their resources on staff, creating a sustainable workforce is a key component of their integrated business plans. NWW can help them achieve a balanced, effective, sustainable workforce offering the care and treatment that service users and carers are asking for. Foundation Trusts have Boards of Governors elected by their members, and there are thus real opportunities for service users, carers, staff and other key stakeholders in the local community to influence the development of their local Trust. Lean thinking is also being actively pursued by some Trusts and SHAs, and NWW will be threaded into this process.

6.2 How does NWW link with other developments like Payment by Results?

The NIMHE NWP is working closely with the Department of Health and has links with the pilot projects for Payment by Results in mental health. There is a good understanding of the need for any mental health tariff to take account of new working practices. The NWP is also making links with Connecting for Health to ensure that the new clinical information systems are not based on outmoded assumptions about who does what and where.

7. Questions for teams to consider to support New Ways of Working

The aim of NWW is to achieve a cultural shift in services which enables those with the most experience and skills to work face to face with those with the most complex needs and to supervise and support other staff to undertake less complex or more routine work. This enables qualified staff to extend their practice (e.g. by delivering psychological therapies, supporting people in employment, and carrying out non-medical prescribing), and provides opportunities for new people to come into the workforce at various levels on the career framework (e.g. STR workers, primary care mental health workers and assistant practitioners).

The following questions were developed to help teams to look at their existing structure and to begin to consider how they can introduce NWW; they are drawn from the CCTA, but can be used by teams that are not currently able to undertake the whole process.

A. Setting the scene

- **Does the team know what is happening nationally in relation to New Ways of Working (NWW) and New Roles?**
  If no see www.newwaysofworking.org.uk
- **Are all the team members aware of examples of NWW and New Roles?**
  If no see www.newwaysofworking.org.uk
- **Does the team know what is happening in their organisation in relation to NWW and New Roles, who is in the lead and what the organisation's workforce strategy is?**
  If no, find out and ask the lead to meet with the team to discuss further.

B. The team

- **Who is in the team?** Names, roles, grades, hours worked.
- **What does the teams' skill mix (sometimes called its Christmas tree) look like?** Fill in the data on the Skills for Health website at www.skillsforhealth.org.uk/careerframework/graph.php and see a visual representation of the team.
- **What does the Christmas tree (numbers of whole-time equivalent (WTE) at each banding) tell you about the shape of the team?**
  - **Is there the right balance of staff within the team?**

  - **Where are the gaps?**
  - **What shape should the Christmas tree be?** Consider how could you change this, e.g. do you need to introduce a new role?
- **What is the team's agreed and current establishment?**
- **Does the team have any vacancies? Could you use them differently?** If there are vacancies, consider how these could be used differently. Do they need to be filled like for like? If there are no current vacancies, think about how you could use any future vacancies differently.
- **Think about the patient's journey and the interventions that are being carried out and by whom. Are the most highly skilled members of the team being used to undertake the more complex tasks?** If not, why not? What needs to change to allow this to happen (e.g. developing an existing role to include non-medical prescribing, or changing a process)?

C. The service

- **Who does and who doesn't the team provide a service for?** Is this reflected in the team operational policy and national guidance? If not, what needs to be done to address this?
- **What are the team's must-dos (contractual agreements, national policy)?** Ensure that all members of the team are aware of these and that they are reflected in the team's operational policy, and consider what implications these have on the service provided.
- **What is the make-up of the population that the team services?** Consider:
  - the population;
  - the age profile;
  - the male/female split;
  - the ethnicity profile;
  - the area covered (rural, urban or coastal); and
  - any local intelligence/trends/statistics that will affect the future needs of the population, e.g. large housing developments, an ageing retirement population, a large population of asylum seekers or a high percentage of teenage pregnancies.

- **Does the prevalence of some types of mental health condition suggest where you should prioritise your work?**
- **How does the information about the local population affect the service that the team provides now? And in the future?** Consider how this may effect the make-up of the team, roles within the team and the team's learning and development needs.

D. Service user and carer needs

- **Does the team have a good understanding of the needs of the service users and carers?** If yes, consider if these are from a service user and carer perspective or from a staff perspective. If they are from a staff perspective, consider how you can work in partnership with service users and carers to determine or confirm their needs.
- **Does the team encourage service user and carer feedback on the service?** If not, how can this be addressed? If yes, how is this used to inform the development of the team?
- **What were the results of the last service user survey for the area?** What can the team learn from this, and how can it inform the development of the team?
- **Are service users and carers truly involved in reviewing the service that the team provides?** If not, how can this be addressed? If yes, how they are involved? Is it true involvement, or tokenism?
- **Does the team feel that they currently meet the needs of the service users and carers?** If yes, consider if this is from a service user and carer perspective or from a staff perspective. If it is from a staff perspective, consider how you can work in partnership with service users and carers to determine their needs.
- **Does the team have the required capabilities to meet the needs of the service users and carers?** If not, what needs to change to make this happen? Don't forget to consider how the existing capabilities of team members can be used to support learning and development.
- **Is the team meeting needs that could be met by other services?** If yes, consider what needs to change to address this.
- **Are there needs that the team should meet but are not currently meeting?** If yes, why are these needs not being met? Consider what needs to change to address this.

E. Individual capabilities (skills, knowledge and experience)

- As an individual team member, consider the following (it may be helpful to keep a diary for a week):
  - **What tasks/interventions/activity do you feel are part of your role?**
  - **What aspects of your role do you think are effective? What are the outcomes?**
  - **What aspects of your role do you feel are not effective?** Consider why and what needs to be done to address this.
  - **Are there any capabilities that you need but don't have, or need to develop?** If yes, consider how you could develop these capabilities. Are there individuals within the team who could support your development?
  - **Are you doing something that does not need to be done by anybody within the team?** If yes, how can this be addressed?
  - **Are you doing something that could be undertaken more appropriately by another team member?** If yes, who, and what needs to change to allow this to happen?
  - **Could you supervise someone else to undertake some of the activity you currently deliver?** If yes, what needs to change to allow you to do this?
  - **Could you share your skills by providing training, mentoring or shadowing to support other team members to address their learning and development needs?** If yes, consider what, to whom, how often, and what needs to change to allow you to do this.
  - **What would you like to do but are unable to do at present? What factors prevent you from doing this? What needs to change to allow this to happen?**

F. Team capabilities (skills, knowledge and experience)

- **Are you aware of the capabilities that exist within the team?** If not, consider a mapping exercise that highlights not only the capabilities of the whole team, but also the gaps.
- **Are there existing capabilities that are not currently used within the team?** If yes, why? Consider if they could be used more effectively, e.g. through a new way of working, supervising others or providing informal mentorship/training.

- **Are there skills that team members need to develop?** If yes, consider if this can be achieved via informal methods, e.g. mentoring or shadowing, as well as formal training.
- **Do team members have skills, knowledge and experience that they could share with others?** If yes, consider how you could use this valuable resource, e.g. through informal training, mentorship or supervision.
- **Are the collective skills of the team, and needs of the service users, considered when training applications are agreed?** If not, how can this be addressed?

G. Working differently

- NWW is about making the best use of the current workforce, providing job satisfaction and career development for staff, providing services that meet the needs of service users and carers and ensuring the efficient use of resources. Taking this into consideration, think about how the implementation of NWW could:
  - ensure that the capabilities of staff meet the needs of service users and carers more effectively;
  - utilise existing vacancies to provide a role that better meets the needs of service users and carers;
  - free up senior staff to work with individuals with more complex needs;
  - change the shape of the team's Christmas tree;
  - meet the needs of the changing population;
  - develop and expand traditional, professional roles;
  - ensure that the capabilities of all staff are used in the most efficient and effective way; and
  - provide a needs-led, value-for-money service.

8. Acknowledgements and contacts

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Further information can be obtained from www.newwaysofworking.org.uk

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9. List of NIMHE NWP publications

The following publications have either been produced or commissioned by the NIMHE NWP:

- Mental Health Workforce Strategy (August 2004)
- New Ways of Working for Psychiatrists – Interim Report (August 2004)
- The Ten Essential Shared Capabilities Framework (August 2004)
- Community Development Workers – Interim Report (December 2004)
- Mental Health Workforce Recruitment and Retention Research Project (January 2005)
- Community Development Workers – Education and Training Supplement (October 2005)
- New Ways of Working for Psychiatrists – Final Report (October 2005)
- Joint Guidance on the Employment of Consultant Psychiatrists (October 2005)
- The social work contribution to mental health services – The future direction (November 2005)
- Recruitment and Retention of Mental Health Nurses: Good Practice Guide (April 2006)
- Report on the NIMHE National Workforce Planning Pilot Programme (June 2006)
- DVD on New Ways of Working for Psychiatrists (summer 2006)
- Recovery Approach learning materials (September 2006)
- Community Development Workers – Final Handbook (November 2006)
- The Ten Essential Shared Capabilities learning materials (March 2007)
- Learning and Development Toolkit (April 2007)
- Mental Health: New Ways of Working for Everyone (April 2007)
- Creating Capable Teams Approach (April 2007)
- The competences required to deliver effective CBT for people with depression and anxiety disorders (September 2007)
- CBT for people with depression and anxiety: What skills can service users expect their therapists to have? (September 2007)

In addition to the publications listed above, a number of additional products have emerged from the NWW programme and these can be viewed on the NWW website at www.newwaysofworking.org.uk

10. Abbreviations

A4C	Agenda for Change
BME	black and minority ethnic
CBT	cognitive behavioural therapy
CCTA	Creating Capable Teams Approach
CDW	community development worker
CMHT	community mental health team
CPA	Care Programme Approach
CPD	continuing personal/professional development
CPN	community psychiatric nurse
CSIP	Care Services Improvement Partnership
ESC	Essential Shared Capabilities
GP	general practitioner
HEI	higher education institution
HR	human resources
IAPT	Improving Access to Psychological Therapies
IT	information technology
MDT	multidisciplinary team
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NWP	National Workforce Programme
NWW	New Ways of Working
OT	occupational therapist
RAG	red, amber, green
RDC	regional development centre
SHA	Strategic Health Authority
STR	support, time and recovery
WTE	whole-time equivalent

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If you require further copies of this title quote
283727/New Ways of Working for Everyone: A best practice implementation guide

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