iapt

Improving Access to Psychological Therapies

NHS

Gathering success narratives

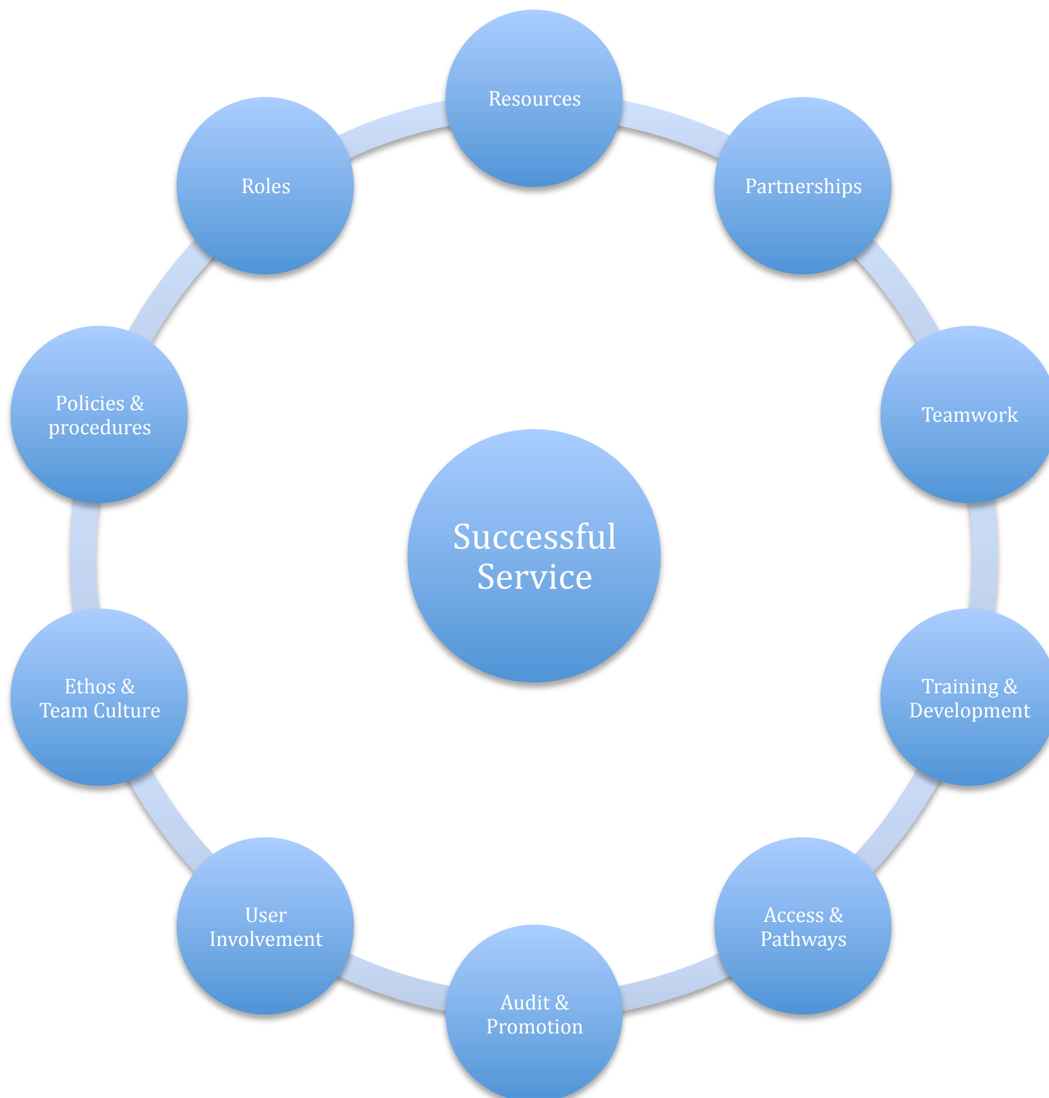
Report complied for IAPT conference 25th March 2010

Kevin Heffernan & Mark Rayne

Programme Specialists

West Midlands Regional Development Centre

Data for the report gathered with North Staffordshire, Shropshire, Stoke and Wolverhampton services



NHS
West Midlands
Regional Development Centre

Background to the project

Following a discussion between the West Midlands Regional Development Centre IAPT team and West Midlands Service Improvement leads; there was a recognition that over the past year, developing West Midlands IAPT early implementer sites have been very busy setting up their teams and meeting commissioned performance targets.

During this time teams have had little opportunity to demonstrate and share success with each other, and their stakeholders. Also they have had little protected time together to review and plan as a team

A proposal was put forward that the West Midland Regional Development Centre (WMRDC) would offer a protected day to all of the early implementer sites to be focused upon gathering success narratives. The day would also be part developmental to allow the teams to think about their next stage development needs.

The day would allow the teams to discuss and capture their journey over the past year and to identify what they feel are the important criteria of a successful IAPT team, how they have measured so far against these criteria, what they need to further develop, what has helped and what has hindered their progress. The day would also use narrative gathering techniques to allow team members to share success from real clinical case exploration

Sessions were offered to all West Midlands early implementer sites but due to their current development position, Walsall & Dudley were not able to participate in these pre-conference sessions.

This project is intended to be complimentary to the wider work of the RDC's IAPT team who are working in many other ways to supporting implementation and development of local services

Next steps

The information collated from these sessions and contained within this regional document will be helpful for other IAPT sites to learn from, informing local planning and development phases. Being able to reflect on the shared learning offered by early implementer sites should enable a proactive approach to understand and plan for tensions that naturally arise when implementing a new service within a complex system. The process also allows sites to reflect on the importance of gathering and sharing success, this seems to have had an energising and motivating impact on all the participating sites

It is anticipated other West Midland IAPT sites may wish to access the developmental sessions over the forthcoming months, and this will be supported by the west midlands regional development centre IAPT programme

The regional report will be shared at the IAPT conference and available on the RDC website www.wmrdc.org.uk

Summary of the collated findings

Some of the things that the developing teams felt *helped* their successful development included:

- Access to good quality resource materials to utilise in sessions which are able to be in different media/languages and to meet the needs of their local communities
- Sharing resources and skills within the team (e.g. positive examples of CDW and STR collaborative working across the service)
- A supportive team ethos and a commitment to make it work
- A training culture and commitment to ongoing training and development (it was noted that there was a big variation of experience of the quality of training, not just across different localities but even within teams)
- High quality supervision
- Having strong support from, and good networking with partner agencies and taking time to outreach into local communities
- Involvement and encouragement from commissioners
- To have good team leadership (someone who values the unique roles with equity)
- To have staff from a diverse background with a wide skill mix to utilise
- Taking time to regularly review the service with Users and stakeholders and refining as needed
- Information sharing and raising awareness of the team with communities and stakeholders
- Developing policies that are IAPT specific and that are owned and utilised by the team and partners
- Wanting to gain feedback as a service and encouraging Users to participate meaningfully in the process of feedback and development
- To prioritise and make the time for regular ‘whole team’ meetings
- For everyone to discuss and explore the development of roles and responsibilities within the team
- To be adaptable and flexible in the early development stages of the team

Summary of the collated findings

Some of the things that the developing teams felt *hindered* their development included:

- Workload pressure together with lack of opportunities to meet as a team leading to some isolation and communication difficulties
- Team members not feeling involved in the decision making process in the development of the team
- The isolated and dispersed nature of the work at times
- Poor inter-team communication
- Lack of feedback from Users on their experience of treatment to gauge what is going well and what needs to change
- Lack of feedback from Stakeholders and referrers on their experience of the team to gauge what is going well and what needs to change
- Not sharing success and promoting the service locally with communities
- The constant change and speed of developments can be overwhelming
- A lack of understanding of the service by referrers and other agencies leading to confusion and inappropriate referrals
- Different services and partner agencies not having the opportunity to meet to understand each others service and role leading to lack of clarity for some pathways and transitions
- The need for training vs. the need to case manage and meet targets can be a balancing act

Summary of the collated findings

The following are a selection of the teams collated development actions

- Developing opportunities to see people in different community settings
- Protecting a budget for materials
- Developing resource directories
- Developing a training strategy which meets local needs, a programme of CPD and top-up training
- Developing self referral options and information outlets
- Developing a service handbook which explains the service and its referral criteria
- Doing local stakeholder analysis (who they are and what they do)
- To learn about each others roles and make more use of the diverse skills in the team
- To make the time to meet as a team
- To promote and publicise the team through different media and presentations
- To develop focus groups and outcome tools / questionnaires with service users and invite them to be involved in the service's development at the end of their treatment
- Develop guides to clarify the roles of high and low intensity workers (PWP's)
- Develop and embed STR and CDW roles within the team

The regional document will be available to download from the RDC website www.wmrdc.org.uk

Contents of the document

Process undertaken by the RDC	Page 7
Breakdown of the development sessions	Page 8
Example of a domain wheel	Page 9
Collated Themes	Page 10
Domain 1 Resources	Page 11
Domain 2 Training & Development	Page 13
Domain 3 Access & Pathways	Page 15
Domain 4 Partnerships	Page 17
Domain 5 Team Culture & Ethos	Page 19
Domain 6 Audit and Promotion	Page 21
Domain 7 Policies and Procedures	Page 22
Domain 8 Service User Involvement	Page 24
Domain 9 Roles & Responsibilities	Page 26
Domain 10 Communication (Internal)	Page 28
Narrative gathering approach	Page 30
Case narrative - Bob	Page 31
What makes us unique?	Page 33
Final feedback from the team	Page 34
Reflections from a service manager	Page 35

Process undertaken by facilitators from the RDC

A meeting took place with lead representatives of each service to offer and explore a proposed agenda for the day. Each area was offered 1 full day from 9.30am till 4.30pm. The day was part developmental and part narrative collection.

Wolverhampton, Shropshire, Stoke and North Staffordshire became the participating sites. The following Information was gathered during the development day to form a local report for each participating site;

1. A team consensus of the critical components (8 domains identified by them from morning exercise of brain storming on posits what is required to deliver a successful service from their perspective and then clustering and naming them into the 8 domains of a success wheel) of delivering a successful service from their perspective in their area

2. A rating of individual, leading to the development of team consensus of where things are now for each of those domains

3. A current reality/desired future narrative from each team member for each domain

4. A description of what is currently helping and what has hindered developments

5. Identification of key action plan themes to move forward/develop across each domain

6. A team reflection on what makes their service unique

We hoped this would also be a great opportunity for the services to develop an action/ developmental plan that is developed and owned from within the team, based on *their* domains.

Finally to close the day, we asked each area to prepare in advance 2/3 case vignettes and using a narrative gathering technique we captured and produced evidence of the important themes within each story.

It was important that the case vignettes were success stories reflecting the depth of service provision locally. On the day one person was nominated as a storyteller for each case and the presentation time was approx 10 minutes for each case *(no formal power-point they just told the story, all other participants then gave direct feedback on what the story meant to them).*

Utilising all of the information gathered from across the services, we have collated key themes and messages into this regional conference report to be disseminated on March 25th 2010.

The report has clustered and themed domains of a successful service, it will identify and help people understand the current reality, what helps and what potentially hinders Implementation/development. It will also give some guidelines/suggestions around action/developmental ideas generated from early Implementer sites.

The case narratives give an opportunity to reflect on good practice and share examples of how these services have had a real Impact on improving the quality of peoples lives

Breakdown of the development day sessions

Session 1….In small groups brainstorming ideas on post-its (1 idea for each post-it) about 'what makes a successful service'?

Session 2….As a team we supported the clustering of post-its into themes. We finished with 8 named domains for each service

Session 3….Each person was then given a 'domain' scoring wheel and asked to consider from their perspective where they believed the service was currently for each domain

Session 4….A whole team open dialogue exploring the differences in individual perceptions for each domain took place. And following healthy discussion a team consensus (an example of a domain wheel is given on the next page).
We recorded information from these open discussions

Session 5….To ensure we had a real depth in capturing all issues, everyone was given individual protected time to write statements for each domain around the following questions;
What is the current reality?
What is your desired future?
What has helped?
What has hindered?
This information was written up as part of the report each participating site received

Session 6….We split into smaller groups and revisited the domains and produced developmental ideas around improving the quality of each domain

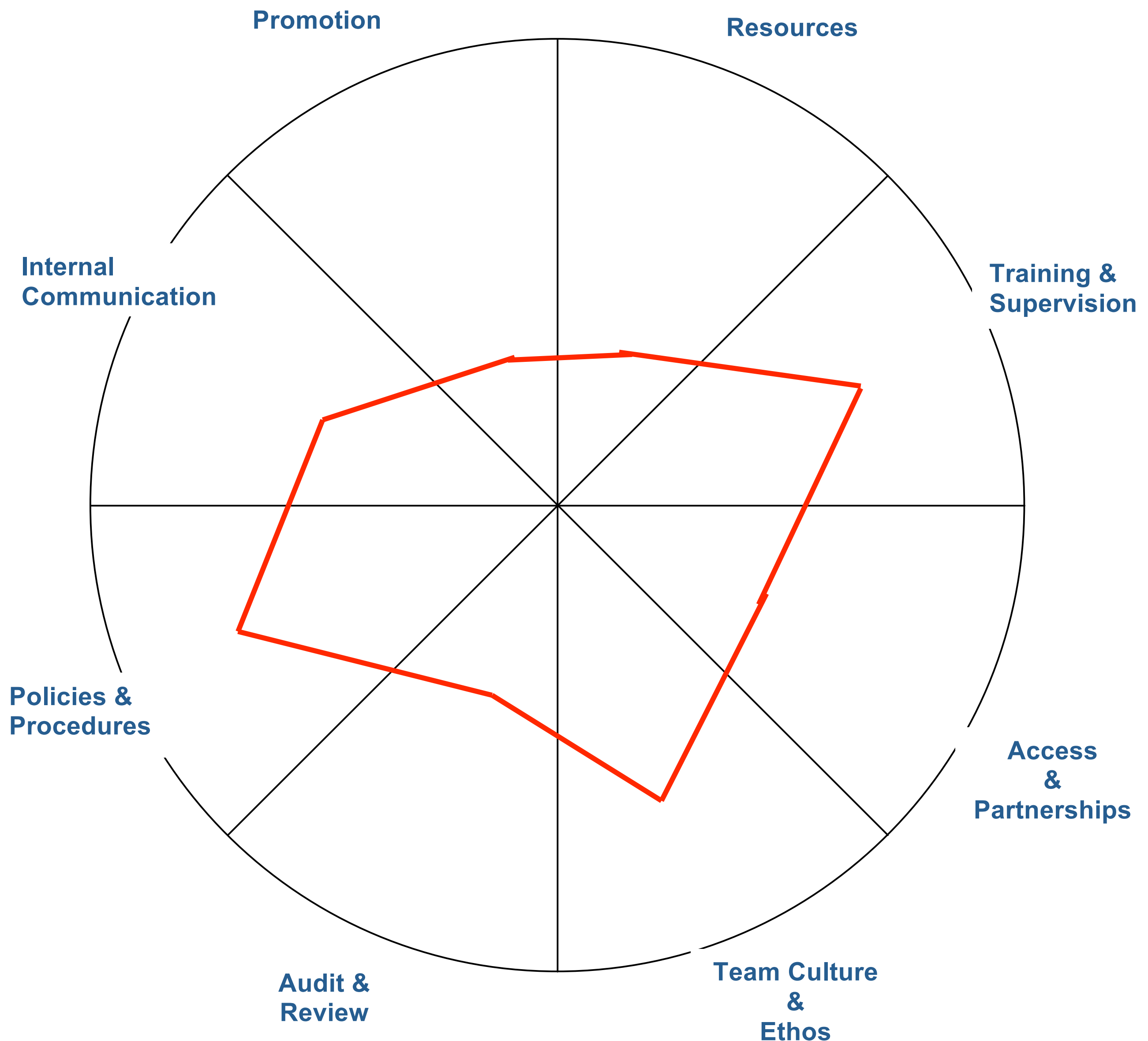
Session 7…. As a large group we gathered thoughts from the team on what they felt made the service unique

Session 8….Using a narrative gathering approach we explored the real success factors found within actual team case studies

Session 9….Finally we asked each participant to feedback 1 thing they took from the day

Example of a domains of success wheel generated on each day

(The following scores mapped into a team wheel built up from individual wheels from each person. After discussion around each domain the team concluded a 'consensus' score for the service)



1. Taking the centre of the wheel as 0 and the outer rim as 5, indicate the level of achievement of your team with each of your key components (plot from the centre of each segment).

2. The eight sections in the wheel contribute to balance – draw a line around the scores. What would the ride be like if this were a real wheel?

Key to scoring: *0 = not happening 1 = poor 2 = reasonable*
3 = good 4 = very good 5 = excellent

These are the collated headings chosen for domains, gathered and named during work across the 4 sites

- ***Resources***
- ***Training and Supervision/ Development***
- ***Access and Pathways***
- ***Partnerships***
- ***Culture and Ethos / Team qualities***
- ***Audit and promotion***
- ***Policies and procedures***
- ***SU involvement***
- ***Roles and responsibilities***
- ***Internal communication/ team-working***

Under each domain heading we will now describe collated examples of

- **the posits which determined the naming of each domain**
- **narrative examples of Current Reality for each of the domain headings**
- **narrative examples of Desired Future for each of the domain headings**
- **narrative examples of What Helped for each of the domain headings**
- **narrative examples of What Hindered for each of the domain headings**
- **Identified action/development ideas for each of the domain headings**

Resources

Examples of post- it's that formed the domain: Resources

- *Having a wide range of self help resources in different formats and languages to meet local need*
- *Having the capacity (workforce numbers) to meet the demand*
- *Having the skill mix (and staff from a wide range of backgrounds) to meet diverse local needs*
- *Being able to offer a wide range of therapeutic interventions*
- *Good computer access and IT resources available, with support*
- *Appropriate venues to see people, which are suitable for clinical need*
- *Having more time to reflect, plan and review*
- *Administrative support*
- *To have accessible and appropriate CBT materials and resources*
- *Having a "central hub" in a large geographical area*

Current reality: Resources

Computer access and IT support variable
Resources variable
Issues of getting resources in different formats and languages
PC-Mis is good
Working space and environment is variable
Staffing is not enough to meet demands of referrals rates
Little reflection time
Balance of staff on training versus case management needs
Great administrative support

Desired future: Resources

A wide range of high quality resources in a variety of languages and formats to utilise and share
Adequate computers and good IT support
More therapy rooms available
Enough staff (and particularly therapists) to meet demands
Telephone workspaces
A choice of places to see people other than GP surgeries
More choices for clients
Better bases
More planning and less fire fighting

What helps: Resources

Good availability of books and some resources
Service treatment protocols
CDW translating materials
IT support
Staff sharing knowledge and resources
Prioritising issues and workloads
Commissioners' commitment
Motivation
Determination
Flexibility
Optimism that it will get better

What hinders: Resources

Lack of direction in decision –making (between tiers of management)
Lack of organisation
Lack of time and money
Large caseloads
Inability to recruit appropriate staffing levels and skill mix
Lack of space and appropriate rooms
Slow protocols and procedures for recruitment
Competing demands of study and caseloads
Unsuitable rooms
Staff moving on
Poor equipment

Domain	**Action planning ideas**
Resources	Better organisation and access to resources- develop a resource directory Share and pool resources more Better admin and therapist communications Developing a budget for materials (and available in a wide range of languages and media e.g Braille) Provision of more clinic rooms and clinic spaces Laptops to be available for staff Recruit more staff to meet local needs

Training, Development & Supervision

Examples of post- it's that formed the domain: Training & Supervision

- Time to reflect on learning and share with the team
- Ongoing training and continuing professional development
- Quality and responsiveness of supervision
- Training that prepares staff for their roles and reflects the client groups
- Being able to implement new ideas
- Induction programme for new staff
- Regular 2 way appraisals
- Group supervision
- Case presentations
- Case management
- Training that is timely and appropriate for need
- PWPs to be involved in NHS training
- Training materials available

Current reality: Training & Supervision

Good in house and university training
Some inequality of access and timing issues (not always at start)
Good supervision
Some inconsistency in training at times
Training doesn't always match the needs of the role or clients
Balance of supervision and case management
Excellent and lots has been invested in training

Desired future: Training & Supervision

Emotional as well as case management supervision
Initial and ongoing training and equitable access for all
Group supervision
Continuing Professional Development opportunities
More regular supervision and to be supportive and educational
Developing holistic approaches
Training as a team
Understanding each others roles in the team
Induction for new staff
Training that matches the needs of our clients
More reflection time and time for research
A clear training strategy that is transparent and understood by all

What helps: Training & Supervsion

The training culture and managements' commitment to training
Accessibility of training
Opportunities to feedback from training with team members
Regular and consistent supervision
Reflection time
A team focus on training
KSF and the acceptance of the need for development
In house training

What hinders: Training & Supervision

Lack of emotional supervision
Development opportunities are limited
Balance of supervision vs. need for case management
Training not preparing you for complex cases
Low intensity training can be inadequate
Lack of time to get together as a team to review and share knowledge learnt
Balance of training vs. case management (day to day work responsibilities)

Domain	Action planning ideas
Training & Supervision	More in house specific training More supervision and following the IAPT/ BABCP format Consistent training which is reflective of clients needs Programme for CPD and top up training Developing a training strategy Peer supervision sessions Dissemination of learning to the team Localities pooling resources to run "expert masterclasses"

Access & Pathways

Examples of post- it's that formed the domain: Access & Pathways

- *To be working out of community sites and to establish community centres*
- *Easy access and self referrals*
- *Integration with and acceptance from other services*
- *Clear protocols and pathways for access and onward referrals and which are owned by all*
- *Ability to prioritise urgency*
- *Access to choices for referrals of individuals of a higher need*
- *Short / no waiting lists*
- *Specific and clear referral/ eligibility criteria for referrers*
- *Equity of access*
- *Good knowledge and use of supportive organisations*
- *Consultation with service users*
- *Shared understanding of roles along and across the pathways*

Current reality: Access & Pathways

Room for improvement and development
Frustrating at times due to inappropriate referrals and lack of clarity
Need better information and communication
Confusing pathways into other services (e.g strengthening connection with CMHT's)
Waiting lists is an issue
Step up and step down is unclear
They are improving and evolving
There needs to be clearer inclusion criteria (what is high and low intensity?)

Desired future: Access & Pathways

Self- referral options to increase where possible
Knowledge throughout the team on referral pathways and options
Knowledge and effective utilisation of roles
Clear pathways, which are seamless, with easy access
Little or no waiting lists
Seeing people in a variety of community settings
Step up and step down is responsive and supportive
Gaps are identified and addressed
A wellbeing service integrated into the PCT, IAPT and other wellbeing providers e.g health trainers, long- term conditions. Run joint promotion and educational workshops.
Closer working with community groups
Development of self -help/ homework is crucial for successful outcomes

What helps: Access & Pathways

Being patch based has reduced travelling times
Previous knowledge and knowledge sharing
New mental health strategy
Commissioners and service leads communicating
Support from partners and good networking
The IAPT model and clinical pathway
Commissioners' need for self- referrals is helping the service expand/ prepare for this

What hinders: Access & Pathways

Lack of clarity on some pathways
Lack of communication
Lack of coordination
Lack of good written protocols, procedures and criteria, which need to be well publicised and communicated
Waiting lists
Lack of self referral opportunities can be related to a high DNA rate
Misunderstanding by some referrers as a result of above

Domain	Action planning ideas
Access & Pathways	Self-referral options and development of information outlets Clear referral criteria for all services More choices of venues to see people Identify community settings and allocate link workers Development of a service handbook, which explains the service and its referral criteria Exploration of flexible working arrangements (e.g to mirror local G.P practices)

Partnerships

Examples of post- it's that formed the domain: Partnerships

- *Excellent communication and feedback with / from GP's and other referrers*
- *Fostering good relationships and support from commissioners of the service*
- *Good collaboration and interagency relationships*
- *Training for referrers*
- *Time to network*
- *Good links with other service providers*
- *Joint interventions with other providers*
- *For referrers and services to have an understanding of high and low intensity work*

Current reality: Partnerships

We need more liaison between services
Good, with increasing support from partners
We need to promote ourselves to develop more community and third sector links
Some good work being done, from a zero start
Need to strengthen relationships with GP's
We are looking at ways to develop pathways for childrens' centres
CDW has built good partnership work with the BME communities and other service providers

Desired future: Partnerships

Every service and agency working together seamlessly
More integration and mutual information sharing
Clearer communication with partners
For GP's and all agencies to have a greater understanding of what we do and knowledge of high and low intensity work
Regular contact with partner agencies with somebody taking responsibility (link workers)
Joint training initiatives with CMHT's
Clarify and develop dual diagnosis and develop protocols
Staff embedded in GP practices and GP's understand our role more fully and value us as part of the wider team
Fluid communication and sharing of resources, support and solid bridges built between organisations

What helps: Partnerships

Good networking with G.P's, commissioners and Third Sector services
Determination from team members
Support from partnership colleagues
Outreaching to referrers and communities (staff explaining what we do, how to refer and what information we need)
Social networking outside of work to maintain good bond between team members

What hinders: Partnerships

Lack of understanding of IAPT by referrers and partner agencies
Services not meeting and sharing information together

Domain	Action planning ideas
Partnerships	To action networking links and develop link -working role (attend partner meetings, get resources and cascade across the team. Be a useful point of liaison for external enquiries) Information packs for other services Mapping of local services including referral criteria Stakeholder analysis (who they are and what they do and all staff to be aware) Host a stakeholder day Facilitating a partnership fayre (stalls of stakeholders all together in one place) Shadowing other services to understand roles

Team Culture & Ethos

Examples of post- it's that formed the domain: Team Culture & Ethos

- *To develop and encourage a sense of belonging*
- *To be integrated as a team and have an ethos of working together*
- *To acknowledge success*
- *Respect for different perspectives*
- *To develop a shared vision*
- *Maintaining high morale*
- *Flexibility and adaptability*
- *Peer support*
- *Flexibility*
- *Enthusiasm, motivated and dedicated staff*
- *Good value base*
- *Commitment*
- *Lack of hierarchy*
- *Clear leadership*
- *Respect for each other*
- *Creativity*
- *Compassion*
- *Dedication*
- *An ethos of openness*
- *Maintain a high standard of professionalism*
- *Encourage sharing of knowledge and skills*
- *Patient centred and recovery focussed*

Current reality: Team Culture & Ethos

Friendly
Positive
Supportive
Having a diversity of backgrounds
Flexible and adaptable
Having a shared vision and values
We have a wealth of knowledge and expertise
Caring for each other

Desired future: Team Culture & Ethos

To spend more time together as a team
To plan goals together
Information and skill sharing opportunities
More understanding of each others' expertise
Maintain good communication
Maintain our strengths as a team (values, culture, caring)
For all to embrace the direction of IAPT (e.g it is not all CBT focused)

What helps: Team Culture & Ethos

Good team leadership
Commitment from the team to make it work
Staff from different backgrounds bringing diverse skills and personalities
Peer support
A positive attitude
Sharing of knowledge and skills
Enthusiasm
Protected time together (away-days)

What hinders: Team Culture & Ethos

Constant change and speed of developments
Some staff shortages
Staff being dispersed and lack of opportunity to meet as a team
Shortage of STR and CDW workers. More STR's would take the pressure off therapists
At the extreme, the distance between high and low intensity can make it feel like "us and them"

Domain	**Action planning ideas**
Team Culture & Ethos	To meet more often as a larger team Management feedback at meetings/ through newsletters Recognising the importance of each others roles Regular PWP meeting and PWP's to attend HIT meeting (including admin, CDW and STR) Buddy system for new starters and in-service induction pack

Audit & Promotion

Examples of post- it's that formed the domain: Audit & Promotion

- Improving the service following audit and review
- Raising awareness of the service
- The importance of information sharing
- Timely promotion and marketing
- Feedback from clients, staff and management
- Clarity on what data to collect and where it is shared
- To balance the need for quality versus quantity
- Time to review and learn from success and failure
- Contributing to the wider evidence base

Current reality: Audit & Promotion

More work needs to be done on promoting the service and sharing our success and outcomes
Good audit and poor promotion
There are issues on promoting the service due to capacity issues

Desired future: Audit & Promotion

More promotion of the service to others (including County wide promotion)
Develop user- friendly outcome forms
Having protected time to promote the service
Constantly review and refine the service following audit
Develop research to raise our profile

What helps: Audit & Promotion

Regular reviews of the service (what is helping and what is not)
Information sharing and raising awareness
Contracts and targets
Minimum data set
IAPTUS
An identified person to lead on audit and promotion

What hinders: Audit & Promotion

Focus on quantity and not quality
Lack of resources to develop research opportunities
A lack of short, medium and long term planning
Fear regarding the future re: finances. Retendering causes a defensive response when not always necessary
Clearly defined outcomes from different interventions across the team (high vs. low)

Domain	Action planning ideas
Audit & Promotion	Share audit information and outcomes with the team Develop a steering group for those team members interested in research Involve service users and partners in service improvement through feedback (focus groups, GP feedback etc) Promote and publicise through media and presentations Develop a newsletter to chart our journey so far Develop an interactive website

Policies & Procedures

Examples of post- it's that formed the domain: Policies & Procedures

- A service strategy is important
- Robust policies and procedures that are appropriate for the service
- Clear clinical protocols to work with (how we all do things)
- Risk management to be understood and owned by all
- Clear organisational policies and procedures and legislation together with streamlined processes
- Clear health and safety and lone working policy
- The ongoing development of procedures as the need arises

Current reality: Policies & Procedures

They are reasonable
We have them in place
They can be confusing at times
General procedures work well but the details need refining and clarifying to ensure consistency
They are dynamic and have developed as we have developed and adapted to meet our needs
There could have been more consultation with staff as they are developed

Desired future: Policies & Procedures

To be integrated in what we do and functioning to help us
To be IAPT specific
Good clear procedures owned by all partners
To be easy to follow and access
Have better sharing of information (shared drive to access)
That the policies and procedures are not constantly changing

What helps: Policies & Procedures

Development of IAPT specific policies
Staff completing protocol manuals

What hinders: Policies & Procedures

Too many policies and procedures from Partnership organisations can cause some confusion

Domain	Action planning ideas
Policies & Procedures	Develop integrated policies and procedures Review and summarise existing policies Set up clear protocols for DNA's and cancellations Consult staff in the development of policies and procedures by circulating with a deadline or core group consultation

Service User Involvement

Examples of post- it's that formed the domain: Service User Involvement

- Responding to dissatisfaction and acknowledging satisfaction
- Gathering feedback using appropriate feedback measures
- Having and monitoring realistic expectations
- Having choice options
- Taking the service to Users
- Having motivated Service Users who are willing to work with us
- To know when we are helping
- Having clarity and consistent messages of our purpose
- Having high quality standards

Current reality: Service User Involvement

We need to do more, as services develop
Lots of positive feedback which is word of mouth but this is not formally captured and disseminated
Takes place on a therapeutic level- get lots of good feedback
Lack of strategic involvement of Users in our services
Satisfaction is very high on the whole
We lack the breadth of feedback
Lack of choice options due to clinic situation and availability

Desired future: Service User Involvement

Patient feedback surveys are made more of an important part of the care process
Bottom up development of the service instead of top down
SU forum and representatives on interview panels, having input in developing service strategies
Service evaluation that includes third sector organisations' that work with service users to find what works and what doesn't
Involvement in recruitment, planning, development and evaluation
More flexible times and venues for SU involvement
Well publicised self referral
Should be more SU's involved not just one
Re-write the patient experience questionnaire
Regular feedback

What helps: Service User Involvement

Feedback is encouraged and monitored
Helping users participate in a meaningful way
Wanting to gain feedback as a service

What hinders: Service User Involvement

Not enough feedback on the experience of treatment
Measures that don't accurately measure what is meaningful for Service Users
Feedback not shared
No SU forums

Domain	**Action planning ideas**
Service User Involvement	Set up focus groups Allow anonymous feedback Allow different feedback mediums On the feedback form insert an offer to get involved in service development Rewrite patient experience questionnaire Support Users to set up self help CBT groups Encourage regular and real time feedback (e.g post blog on the website)

Roles and Responsibilities

Examples of post- it's that formed the domain: Roles and Responsibilities

- To have a process in place for staff development
- To have good administrative support and systems
- Supportive management and regular team meetings with management
- Clear Hi and Li worker linkage
- Clear organisational focus
- CDW /STR support
- Role clarity
- Good team and management structure
- Good communication between managers/ decision makers and staff
- Good leadership
- Knowledge of individuals' roles within the team

Current reality: Roles and Responsibilities

Good leadership
Good and wide range of backgrounds and skill mix within the teams
Evolving all the time
There is a high expectation on some roles
Good cooperation between high and low intensity workers
More clarity needed on guidelines, roles and interfaces
Roles and responsibilities are variable
Need clarity on step down
PWP's are not involved in decision making
Management are accessible and supportive
We need to understand each others roles (especially STR) to utilise more

Desired future: Roles and Responsibilities

Everyone clear about their own roles and responsibilities
Clarity on the interface between high and low intensity workers and IAPT/ non-IAPT staff
Everyone is valued for the role that they play and what they do
A flow chart to clarify the process for high and low referrals
An individual to take responsibility for waiting lists and prioritiy referrals
Assessment guidelines
PWP's valued equally as high intensity workers and involved in decision making and service protocol development
A development of the senior PWP role for PWP progression
To get clarity and build on the STR worker role
To have specialist sub teams or workers
To have clearer streamlined processes

What helps: Roles and Responsibilities

Regular team meetings
Good leadership from managers and clinical leads
Shared responsibility to develop a shared approach
Everyone's willingness to discuss and explore development of roles and responsibilities

What hinders: Roles and Responsibilities

Some lack of decision- making and direction from a hosting organisation leads to a dilution of leadership responsibilities across all of the roles within IAPT
Lack of sharing and learning opportunities from other IAPT areas
Targets
Some lack of consistency in how we are working
PWP's are not involved enough in decisions and their views are not always able to be heard

Domain	**Action planning ideas**
Roles and Responsibilities	Regular networking between PWP's and high intensity workers to exchange role information Management to clarify and demark roles and responsibilities Develop a guide to clarify the role of PWP and high intensity workers Develop STR and CDW roles and further embed in the service Identify roles and communicate to all staff to enable effective utilisation of skills Bi-monthly bridging meeting involving people from different services

Internal Communication and Team working

Examples of post- it's that formed the domain: Internal Communication

- Lack of a blame culture
- Consistency of communication and procedures across the service
- Promoting good levels of staff retention
- Work / life balance ethos
- Staff care and a supportive work structure
- Good team dynamics
- Regular team meetings
- Motivated workforce
- Excellent inter-team and management communication
- Peer support
- Transparent process that aids a shared perception of risk

Current reality: Internal Communication

A good sense of team
Colleagues are special
Well motivated and cohesive team
A sense of goodwill and all team members are approachable
There is some isolation at times from the larger team and lack of meeting up is a problem as this leads to mixed or lack of information at times
Email is not the same as meeting up as a team
At times there is a lack of effective internal communication
Communication is good considering the logistics of working a large geographical area
This is difficult, HIT's are dispersed, team cannot always attend meetings on a weekly basis as some trainees are at University on different days

Desired future: Internal Communication

More opportunities to meet and staff prioritising meetings
Moving towards cluster teams and devolving duties to the teams
Good staff inductions
Better exchange of expertise to broaden all team members knowledge base
Better work/ life balance
Good staff retention
Open and consistent communications to inform staff of changes and to give feedback
A building big enough for all of us to work in and communicate from

What helps: Internal Communication

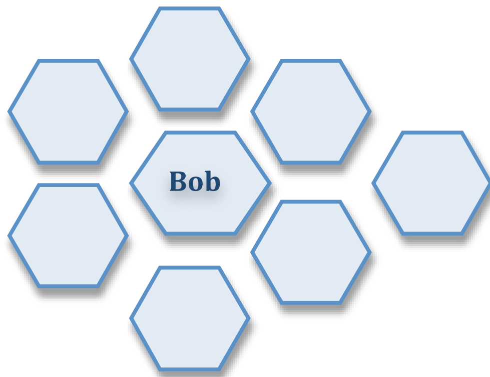
Having great people to work with
Good supportive, approachable management team
Adaptability, flexibility
Commitment and belief in the service and a wish to improve things
Good will and enthusiasm
Team work, peer support and team meetings
Learning from each other
Regular team meetings
Accessibility and approachable management supervision
Consistency and consensus of opinion

What hinders: Internal Communication

Workloads and lack of time to meet
Poor communication at times leading to inconsistent information and confusion
Lack of involvement in decision making
Staff not prioritising meeting up
Dispersed nature of the work
No central base for communication

Domain	**Action planning ideas**
Internal Communication	Better cascading and sharing of information within the team Regular reflection and review of workloads More opportunities for staff to come together (team meetings, away-days, working lunches) Clinical governance issues to be shared Better use of email and bulletin boards Mechanism (clinical supervision meetings) which enables staff to raise problems which affect their welfare in work and also bring the whole team together To set up working lunches, circulate a global email list, staff to check emails daily

The process of narrative gathering used in the sessions

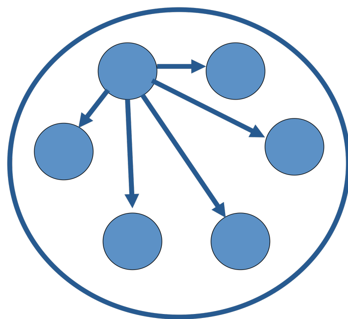


One person tells a case story at a time (10 minutes maximum), they give it a name (e.g. Bob) and write it on a hexagon card

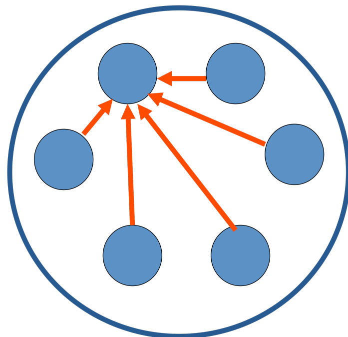
The listeners write down 'what they get' from that story (in 6/8 words) on their hexagon card

Each listener is invited to share with the group and join their hexagon with the others

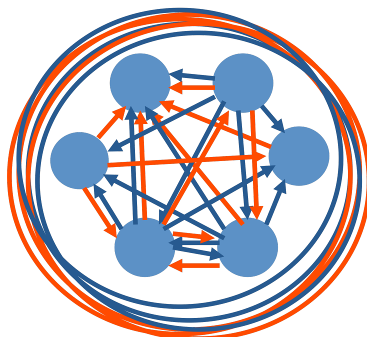
You can then remove the story name hexagon, look for patterns in the responses and cluster the remainder by theme. Give each theme a name
You can then explore the knowledge shared, points of interest, success indicators, unexpected themes, concerns or any important Issues



When you share a story



When you receive feedback it forms a positive barrier/boundary around the listening group



Boundary=Identity=Culture becomes emergent

Boundary emerges that encloses identity and sense of belonging.

This is great way not only to bond the team, but when used with external stakeholders, it can give them a real sense of the depth of quality from multiple perspectives

BOB (following information used during one of the sessions)

Bob was a 39 year old, single man who was on Employment Support Allowance following a injury he sustained at work. He had lost his flat and job as a result of his injury and was now living with his parents. He also had a history of cannabis use between the age of 15 and 35.

He was referred by his GP to the Service for help with his depression. His initial PHQ-9 score was 18. At assessment with the High Intensity Therapist, he set three goals: learning how to relax, learning how to manage his down days and improving his sleep.

The main aim of my first session with Bob was to gain an understanding of why my client felt depressed and to understand the world from his perspective. From listening to his story, I picked up that 'loss' and 'loneliness' were important themes in his life, which seemed to be contributing to his low mood. Particularly, his injury had meant he had lost his job and, therefore, his routine, sense of purpose and his daily contact with others. Also, this loss meant he was managing chronic pain and was not able to do the things he used to enjoy, like reading and painting. The second loss impacting on his mood was as a result of his cannabis use. He was experiencing memory problems, irregular sleeping patterns and had realised that the people who he used to smoke with were not the friends he thought they were as they were no longer interested in him.

At the end of the first session, I gave him a Northumberland Guide on Low Mood and Depression as he knew little about this; I taught him a breathing and relaxation exercise to practice and asked him to try a memory technique to help with his reading.

By the second session, Bob had tried all of the self-help strategies and had gained a lot from the techniques he was given. Today, I wanted to help Bob understand the connection between his activities and his mood and so asked him to keep a Weekly Activity Schedule. We also looked at sleep hygiene and identified some areas for change.

In our third session, Bob was persisting with the sleep advice although this was difficult and was still getting positive benefit from the memory and relaxation advice. He was able to reflect on his Weekly Activity Schedule and could see that his inactivity was unhelpful. The challenge in this session for him was in considering taking up some of his old hobbies as, in his view, if he could not go about them as he used to, he would rather not do them at all. I gave Bob a Decisional Balance Sheet to consider the pros and cons of compromising and not compromising in this area.

By our fourth session, Bob had been on holiday with his parents and was able to again reflect for himself on the importance of doing things. As a result, he had begun to paint again and was considering taking up his photography again. Today, I wanted Bob to understand how helpful increasing social contacts might be for his mood. Although Bob wanted to do this, he admitted that was afraid to do so. To help him understand this, I drew this out for him in a Force Field Analysis to look at what was driving him to make these changes and what was restraining him. My knowledge of local services and agencies helped him to see how change could be possible.

Our fifth session was our final session. By this point, his sleeping had improved somewhat, he was painting, doing his photography and had enrolled on a confidence building course. His PHQ-9 had reduced to 2 and he was happy to continue maintaining the changes he had made on his own.

Case Narratives.

Example of feedback from a narrative gathering technique Used in during the sessions in exploration of a team success story

Feedback from Case Study – BOB

- *A comprehensive and holistic approach working collaboratively to optimise the benefit to client*
- *The bravery of the client and the practitioner was inspiring*
- *There is a light at the end of the tunnel*
- *You were his easel and he painted*
- *Achievable steps used to create a better life for the client*
- *Your skills in the PWP role were innovative, creative, empowering and rewarding both to client and therapist*
- *Listening, motivational techniques so client makes own decisions*
- *Versatile in the approached she used to get best outcome for client*
- *Empathy towards clients loss of identity – helped him to reach his goals by offering support throughout*
- *Kira's positive approach to helping Bob help himself to a better future*
- *A great use of different tools*
- *Created a sense of achievement – optimism with knowledge of resources*
- *Kira was very person-centered, empathetic, creative, patient and matched her communication style perfectly to a client who was very stuck.*
- *You explored his concerns without pressure or forcing him to change*
- *I really listened to the client*
- *Kept client focused on goal. Gently challenged client*
- *Collaborative experimentation and appropriate use of interventions*
- *Solution focused and therapy built on Bob's existing strengths*
- *A really good understanding of the client and knowledge of what would help*
- *Creative inspirational working towards client needs*
- *The client was empowered and motivated by his therapist which continued throughout therapy*

What makes the service unique?

(We asked all the teams the above question and captured the following thoughts which are some of the ideas generated from whole team discussions)

Good Partnerships With the 3rd sector

A better understanding of local needs

Putting steps 1 & 2 out there!

Good relationship with advocacy services

A real sense of investment in the service

Our Relationships With our commissioner

We work practically with an individuals problems

It works!

Defined service around what people need!

Trailblazers!

Feeling so supported

Diversity of skills

Recognition of each others roles

Ability to deal with complex cases but use simple language

Done a lot together in a short space of time

Delivering the best model and evidence base

Flexible and willing to learn new ways

Giving people choice and options

Stick-ability!

Final round robin capture

(Each person asked for 'One thought from the day')

Examples of responses

It has reminded us of our good work

I have learnt more about others in the team

A timely reminder of our strength

Amazing bunch of people

Very emotional day

It confirms a high aiming future

Team bonding

This day has been inspirational

Our uniqueness is important

Having the commissioner has been a real positive

Changed from being negative to positive now

Nice to reflect on what we are doing well

How much we value our managers

Nice to see all the therapists together

Good to balance positive & negative

The case studies were great

We need to take more time out

This has reminded me what a good team this is

It's good to reflect on how we have grown

Finding commonality and consensus

It has been good to be heard

SOME PERSONAL REFLECTIONS ON THE DEVELOPMENT DAY 21/1/10

Like many IAPT services, Healthy Minds has been through a process of rapid growth over the last 12-18 months. We have recruited a substantial number of staff, established new clinical services, built relationships and strengthened alliances, both internally and externally. This has at times been exciting, at other times apparently chaotic and stressful.

We have developed into quite a large team and have limited opportunity to meet as a whole team. When we do meet, discussion tends to focus on practical and procedural issues and space to reflect is limited. Reflection and mutual recognition takes place in the team but mainly in clinical supervision and informal encounters between team members. As Lead for the service, I am aware that the team is reasonably healthy and team members support one another. However, around the time of the Development Day, I was also aware that changes had created stresses and strains and some colleagues were frustrated by recent experiences of poor communication and lack of consultation.

The Development Day enabled me to give responsibility for the day to the facilitators and the group and to share in a rare opportunity to reflect on our work as a team. Most of our team were present, including valued administrative staff, our Commissioner and third sector partners. I think we were able to speak openly and honestly about our strengths, problems and needs and, with the help of the facilitators, see the comments collated and mapped. The event energised the team and strengthened our morale. It has made me even more proud of my team and their determination to realise the promise of the IAPT project- the opportunity to make a real difference to the lives of people with mental health problems.

Dr Brian Simpson, Clinical Lead, Wolverhampton Healthy Minds

We would like to thank all participants for their openness, honesty and enthusiasm throughout the development days

The regional document will be available to download from the RDC website www.wmrdc.org.uk