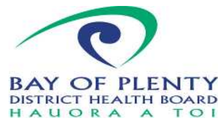


Midland Region Co-existing Problems Strategic Plan

2010 – 2015

MIDLAND REGION CO-EXISTING PROBLEMS STRATEGIC PLAN

DATED THE 25th DAY OF January 2011

ISSUED BY
MIDLAND REGIONAL NETWORK on behalf of the MIDLAND DHBS

Signed by ______________________________
On Behalf of the GMs Planning & Funding
(Tairawhiti, Lakes, Bay of Plenty and Taranaki)

CONTENTS

1. INTRODUCTION....4
1.1 NATIONAL DIRECTIONS....4

2. MIDLAND REGION BACKGROUND AND CONTEXT....6
2.1 REGIONAL ACTIVITIES....6

3. MIDLAND REGION APPROACH....6
3.1 DISTRICT CEP ACTION PLANS....6
3.2 ASSUMPTIONS....6

4. MIDLAND REGION STRATEGIC ACTION PLANS....7
4.1 TAIRAWHITI DHB....7
4.2 LAKES DHBS....11
4.3 BAY OF PLENTY DHB....**ERROR! BOOKMARK NOT DEFINED.**
4.4 TARANAKI DHB....17

1. INTRODUCTION

Co-existing substance use and mental health problems (CEP) are common in those presenting to both mental health and addiction services in New Zealand. Despite innovative and sustained efforts in some parts of New Zealand to serve the needs of people with these complex health issues, there remains an absence of guidance for services and District Health Boards (DHBs). Good practice, where it has developed, has been the result of the outstanding commitment of individuals and agencies, but there is still no consistent framework.

The expectation is that mental health and addiction services need to CEP client needs in a coordinated and complementary manner. There is a high prevalence of CEP in clients presenting to either mental health or addiction services across the age and continuum of care spectrum from primary through to tertiary. It is estimated that 7.7% of New Zealanders will have experienced two or more disorders at the same time in the last 12 months[1].

This plan outlines the actions that will be undertaken by the Midland Region District Health Boards contracted to provide community and clinical mental health and addictions services. The intention of the plan is to integrate treatment and enhance our providers ability to be CEP capable and responsive to the client whaiora and family whanau journey.

This plan is relevant to the Tairawhiti, Lakes, Bay of Plenty and Taranaki DHBs. It excludes the Waikato DHB who will submit their plan separately.

1.1 National Directions

Te Kokiri, The Mental Health and Addiction Action Plan 2006 - 2015 identified the need for a coherent national approach to co-existing mental health and substance use/abuse disorders and the need to strengthen partnership relationships between mental health and addiction services.[2]

In 2008 the Ministry of Health (MoH) and mental health and addiction service providers gathered together in four regional workshops to discuss priorities and to share initiatives for responding to the diverse needs of people with CEP. These meetings confirmed that there are challenges at many levels.

- Models of care may have overlooked or excluded the needs of clients with substance use issues.
- Peer-led models of service delivery are inconsistent, especially in the addiction sector.
- Guidelines for clinical practice for CEP have been available for a decade, but they have not been accompanied by clear expectations of services.
- Integrated service provision has occurred at the client level, however, sustained and committed policy, service management and clinical leadership have been lacking.
- Service delivery pressures have impacted on proactive planning and development necessary for a coordinated response.
- Tension between the mental health and addiction sectors was highlighted.
- Significant challenges in justice settings, including youth justice, forensic mental health and prisons.

The MoH released the following documents in 2010 to guide DHBs to develop a comprehensive framework to ensure services become CEP capable:

---

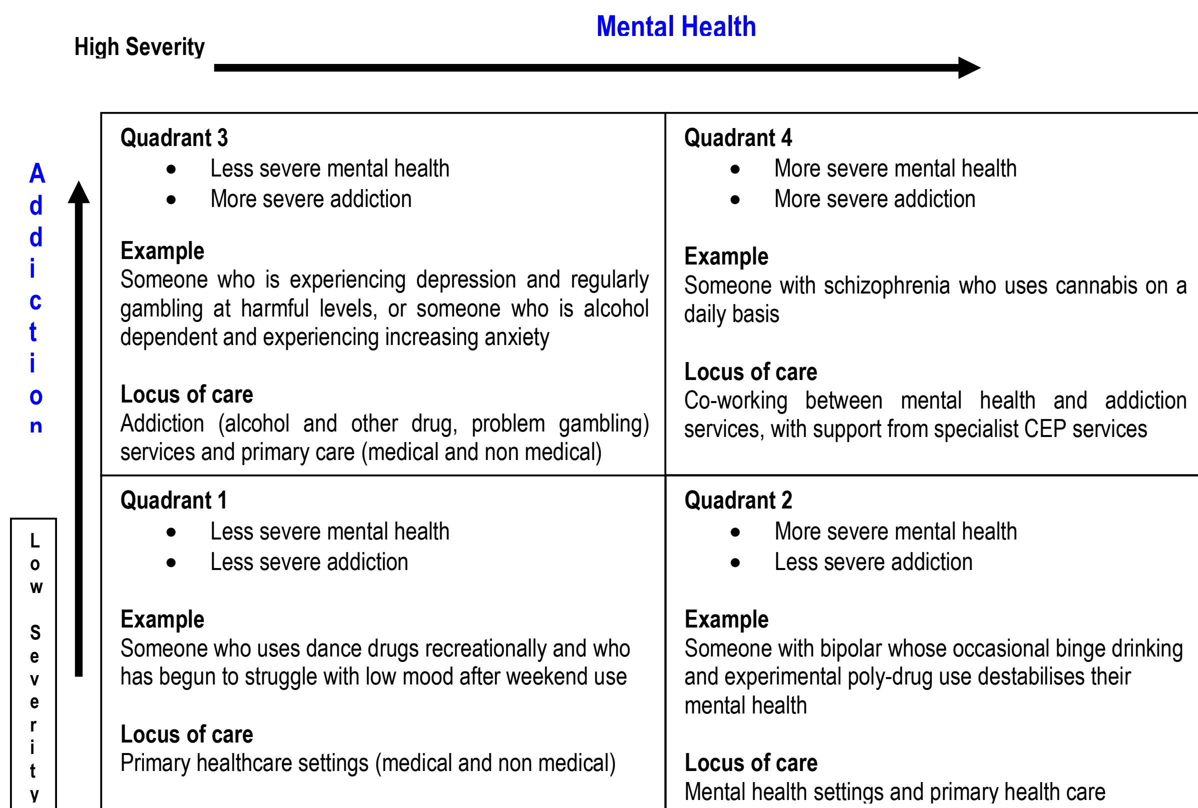
[1] Te Rau Hinengaro: the New Zealand Mental health Survey. Wellington MOH 2006
[2] Te Kokiri The Mental Health and Addiction Plan 2006 -2015 MOH 2006. page 58

1. Service Delivery for People with Co-existing Mental Health and Addictions Problems – Integrated Solutions.

2. Te Ariari o te Oranga – The Assessment and Management of people with Co-existing Mental Health and Substance Use Problems.

Treatment for CEP clients whaiora and family whanau is dependant on integration occurring along a continuum, and involves integration between multiple services. Integration can occur at a number of points in the clinical pathway. All services are expected to aim for integrated screening and assessment, most services should aim for integrated assessment and case formulation and some services should aim for full integration[3].

The **Quadrant of Care Conceptual Framework** demonstrates how integration of individual care and service delivery could occur[4] and has been utilised to assist the Midland region with the development of the DHB specific Action Plans.



[3] Service Delivery for People with Co-existing Mental Health and Addiction Problems 2010 MOH page 19
[4] Service Delivery for People with Co-existing Mental Health and Addiction Problems 2010 MOH page 13

2. MIDLAND REGION BACKGROUND AND CONTEXT

2.1 Regional Activities

Since the 2008 MoH regional workshop the Midland Regional Network has supported the following CEP activities:

- June/July 2009 – Midland Regional forums – MoH update on CEP progress
- May 2010 – Midland DHB and P&F CEP meeting re next steps
- July – August 2010 – Midland DHB specific Next Steps workshops with MoH
- October - November 2010 – Midland DHB CEP Strategic Plan development
- November 2010 – National and regional rollout of Case Formulation Workshops

It is envisaged that the Midland Regional Network will continue to work closely with the individual DHBs to ensure support and alignment with the Matua Raki, Werry Centre and MoH expectations.

3. MIDLAND REGION APPROACH

3.1 District CEP Action Plans

It was agreed that a regional approach would be utilised to develop a Midland Region Co-existing Problems Strategic Plan 2010 – 2015, excluding the Waikato DHB who will submit separately.

A focus group approach was undertaken in each of the participating DHBs involving planning and funding, provider arm services, non-government organisations, Iwi and primary health. The focus group was tasked with developing a high level action plan which was distributed sector wide at a local level for feedback.

Each action plan has been developed with the key focus being on each DHBs priorities for development.

3.2 Assumptions

To ensure that this plan is realised and progress is monitored, the following assumptions have been agreed to across the participating DHBs:

- There is agreement and a willingness across the sector to become CEP capable.

- That services are fully aware that no additional funding will be made available to implement the DHB specific Action Plan.

- The DHB specific Action Plans are high level and further work will be undertaken in each district to further develop the goals and actions.

- The Midland Regional Network will continue to provide implementation and monitoring support and brokerage at a local, regional and national level.

4. MIDLAND REGION STRATEGIC ACTION PLANS

4.1 Tairawhiti DHB Mental Health & Addictions Co-existing Problems Action Plan 2010-2015

Goal 1: Client Centred – a coherent and comprehensive understanding of the needs of Tangata Whaiora, Whanau and Families					
Objective	*Actions*	*KPI*	*Responsibility*	*Completion Timeframe*	*Tools and Resources*
Documented client pathway that reflects services access – Primary through to Tertiary across the age range	Development of agreed integrated pathway that is inclusive of: ▪ Provider arm ▪ NGOs ▪ Iwi ▪ PHO (NGOs, Iwi, PHO: Whanau Ora Recovery)	▪ Agreed policy and procedures signed off by TLAG ▪ CEP specialist roles are implemented ▪ PRIMHD data	▪ P&F, Service Managers and Leaders	▪ Dec 2011	▪ Service Delivery – Integrated Solutions ▪ Client Centred pg 14-17 ▪ Tools for service development pg 22-23 ▪ Appendix 2 pg 41-42 - Screening & Assessment
	Develop Primary Mental Health demonstration that is CEP capable: ▪ Moderate to severe enduring MH cohort ▪ Enduring medical conditions and MH&A	▪ Pilot planned and integrated with MoH Primary demonstration expectations ▪ Screening Tools are agreed and implemented	▪ Te Pare/Rob	▪ 2012-13	▪ Dual Diagnosis capability checklist http://dualdiagnosis.ning.com/ ▪ The Seven Helpful Habits of Effective CAMHS and CAPA http://www.werrycentre.co.nz/ ▪ Appendix 2 – Screening and Assessment Tools

Goal 2: Service Development – services need to be responsive to CEP and to work towards being CEP capable					
Objective	*Actions*	*KPI*	*Responsibility*	*Completion Timeframe*	*Tools and Resources*
MH and Addiction Services are integrated to ensure that any door is the right door	Integration of MH and AOD services in Provider Arm	▪ Single comprehensive assessment that follows the service user ▪ Agreed policy and procedures signed off by TLAG	▪ Manager MH AOD Specialty and Clinical Leaders	▪ 2011-12	Service Delivery – Integrated Solutions ▪ Quadrants of Care pg 13 ▪ Continuum of service capability pg 19 ▪ Service level agreements pg 21 ▪ Service training strategies pg 21 ▪ Process mapping http://www.tepou.co.nz/ ▪ Seven Helpful Habits and CAPA http://werrycentre.co.nz/
	Single point of entry for all MH and AOD service users across the provider arm inclusive of: ▪ CAMHS ▪ MHSOP	▪ Triage function established with policies and procedures that include CEP expectations ▪ Screening tools are agreed and are implemented	▪ Manager MH AOD Specialty, CAMHS Manager and Clinical Leaders	▪ Dec 2011	
	NGO integration with provider arm services to ensure CEP capability is build at the same time	▪ Increase in training opportunities ▪ Improved relationships and shared care ▪ Increase in access of clients to care	▪ P&F, sector Managers and Leaders	▪ 2012-13	▪ Information sharing pg 24 ▪ Tips for MH&A service managers and clinical leaders pg 29-30 ▪ Appendix 1 & 2

Goal 3: Integrated Systems and Care – systems are to acknowledge and incorporate CEP approaches					
Objective	*Actions*	*KPI*	*Responsibility*	*Completion Timeframe*	*Tools and Resources*
Collaborative approaches to integrated care that ensure clinical support and inter-agency working	Specialist CEP consults and liaison clinicians available to all MH, NGO, Addiction and Primary Mental Health Services	▪ Job Descriptions are reviewed to include CEP expectations ▪ Specialist roles implemented ▪ Increase of number of client identified as having CEP issues	▪ Provider Arm, NGO, Primary, CAMHS and MHSOP Managers and Clinical Leaders	▪ 2011-12	Service Delivery – Integrated Solutions ▪ Quadrants of Care pg 13 ▪ Continuum of service capability pg 19
	MDT process specifically focused on CEP whaiora	▪ Robust MDT process developed and CEP reviews scheduled regularly between continuum	▪ Manager MH AOD Specialty	▪ Dec 2011	▪ Service training strategies pg 21
	Continuum of care model links effectively to community NGO services	▪ Integrated care is clearly defined and applied ▪ Capacity is built sector wide ▪ Opportunities for shared care, supervision, case management are developed	▪ P&F and TLAG	▪ 2011-12	▪ Information sharing pg 24 ▪ Tips for MH&A service managers and clinical leaders pg 29-30 ▪ Appendix 1 & 2

Goal 4: Workforce Development - a highly skilled workforce that is CEP responsive and effective					
Objective	*Actions*	*KPI*	*Responsibility*	*Completion Timeframe*	*Tools and Resources*
Services support training initiatives provided nationally, regionally and locally	Workforce plan developed for the continuum to build capacity and capability in CEP	▪ A local plan is developed that links to the regional and national imperatives ▪ Training programmes developed ▪ Two people sponsored to undertake Anamata Diploma in CEP annually	▪ P&F, TLAG & Midland WFC	▪ 2011 - ongoing	Service Delivery – Integrated Solutions ▪ Workforce development pg 24-26 ▪ Staff professional development plans ▪ Staff training budgets ▪ Lets Get Real http://www.moh.govt.nz/ ▪ Dual diagnosis support http://dualdiagnosis.ning.com/ ▪ Matua Raki, Te Pou, Werry Centre and Midland scholarships www.midlandmentalhealthnetwork.co.nz

4.2 Lakes DHB Mental Health and Addictions Co-existing Problems Action Plan 2010 - 2015

Goal 1: Client Centred – a coherent and comprehensive understanding of the needs of tangata whaiora, whanau and families					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources required*
Service promote client-centred treatment and recovery	▪ Joint training / shared language / understanding is developed across the services ▪ Agreement and implementation of standardised screening tools across the district	▪ Shared policy and procedures / assessment tool that is CEP sensitive ▪ Right skill mix: right people, right role ▪ Reduction of multiple access points – any door is the right door ▪ Agreed screening tools are identified and implemented	▪ Workforce Coordinator ▪ MoH ▪ Service Managers ▪ Clinical Managers ▪ MH & AOD Clinicians ▪ Consumer & Family Advisors	▪ 2013	▪ Training / staff / opportunities culturally appropriate ▪ Scholarships ▪ Integrated Solutions pg 22-23 ▪ Appendix 2: Screening and Assessment Tools
Documented client pathway that reflects service access	▪ Shared client pathway document documentation that is clinically and culturally appropriate ▪ Review of Continuum of Care to develop clear understandings of CEP principles and practices (uniform culture shift) ▪ Agreed pathways are developed across the age range	▪ Shared client pathway and documentation is developed	▪ Planning & Funding ▪ Service Manager ▪ Clinical Director	▪ 2011	

Goal 2: Service Development – services need to be responsive to CEP and to work towards being CEP capable					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
CEP prioritisation within service planning	▪ Managerial / leadership – buy in and support to the Lakes CEP Action Plan ▪ Training, developing staff and retention of staff is enhanced through national, regional and local cross sector training	▪ Agreed CEP implementation goals are developed by the leadership group ▪ CEP capable services are developed across the continuum	▪ P&F ▪ MH & AOD Leadership ▪ Consumer & Family Advisors ▪ Workforce Coordinator	▪ 2011/12	▪ National and regional Workforce strategies ▪ Funding for facilitated Leadership forums
Review need for CEP Enhanced Practitioners resource	▪ Identify existing Dual Diagnosis funding and contracts ▪ Review existing contracts and align to CEP Enhanced Practitioner roles ▪ Workshops are undertaken to integrate CEP Specifications into roles and responsibilities	▪ Existing funding is identified ▪ CEP Enhanced Practitioner roles are developed ▪ Improved access to specialist across the sector ▪ Expertise utilisation and sharing e.g. supervision & case management	▪ P&F/MR Director	▪ 20111/12	▪ Integrated Solutions pg 13, pgs 20 – 25 ▪ Matua Raki CEP Practitioner framework
Development of comprehensive local and regional plans and strategies to increase CEP responsiveness	▪ A regional plan is developed ▪ A Lakes plan is developed	▪ Regional and Lakes plans are aligned ▪ Strategies for increasing CEP capable services are identified	▪ Midland Regional Director ▪ Lakes LAG ▪ Lakes sector	▪ 2010	▪ Integrated Solutions pgs 30 - 36 ▪ MoH Workshop information

Goal 3. Integrated systems of care – systems are to acknowledge and incorporate CEP approaches					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Service leaders collaborate	▪ A CEP Working Group is convened comprised of Leaders and Senior Clinicians to drive CEP integration and organisational culture shifts: o Develop Terms of reference o Develop Job Descriptions o Implementation of Action Plan objectives are developed ▪ Consumers and Family are consulted	▪ Key decisions are made and service development for funding ▪ Positive relationships collaboration are built ▪ Funding mechanisms to support recovery are identified and implemented	▪ P&F through Lakes LAG	▪ 2011 ongoing	▪ Integrated Solutions pgs 23 - 24

Goal 4: Workforce Development – a highly skilled workforce that is CEP responsive and effective					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Develop a Lakes Workforce Plan 2011 - 2015	▪ A comprehensive Workforce Development Plan is developed that includes but is not limited to: o Takarangi Competency o CEP Tool Kits o Screening tools	▪ Alignment to national workforce strategies from Matua Raki and Werry Centre ▪ Alignment to the Midland Regional Workforce Plan	▪ Midland Workforce Coordinator ▪ P&F ▪ Lakes LAG	▪ 2011 ongoing	▪ National workforce annual programme ▪ Regional workforce annual programme
Responsiveness to cultural diversity	▪ Core documentation, screening, treatment and discharge processes will be culturally appropriate ▪ Existing policies and procedures are reviewed to ensure inclusion of CEP and cultural competencies ▪ Workforce opportunities from Te Pou, Le Va and Te Rau Matatini are implemented e.g. Takarangi Framework	▪ Services and access for Maori, Pacific, Asian and refugees is enhanced	▪ P&F ▪ Midland Workforce Coordinator	▪ 2011 ongoing	▪ National Workforce Centre Workplans

4.3 Bay of Plenty DHB Mental Health and Addictions Co-existing Problems Action Plan 2010 – 2015

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Goal 1: Client Centred – a coherent and comprehensive understanding of the needs of tangata whaiora, whanau and families					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Tools and Resources*
Policy & practice are CEP responsive	▪ Enable CEP responsive through, contracting & monitoring ▪ Alignment of all policies & procedures to reflect CEP objectives ▪ Any door is the right door	▪ Provider contracts are aligned to CEP expectations ▪ Service policy is orientated to the clients journey	▪ P&F ▪ Service & Quality Mgrs ▪ Sector wide	▪ 2011 ▪ 2012/2013	▪ National MH&A Specifications Framework ▪ Service Delivery – Integrated Solutions pg 14 ▪ 7 key principles
Documented Pathway across the continuum	▪ Cross sector process mapping to develop a documented pathway ▪ Evaluate effectiveness ▪ Cross sector consumer family satisfaction service / survey is developed ▪ Consumer / family whanau participate in the development of a documented pathway ▪ Hub & Spoke model is developed	Client access is measured by: ▪ Qualitative analysis ▪ PRIMHD data ▪ Case load reporting ▪ In-house file audits ▪ Contract audits ▪ Consumer, Family whanau Survey	▪ Midland RN Director, Matua Raki, Werry Centre & P&F ▪ P&F & Midland WFC	▪ 2011/2012 ▪ 2015	▪ Service Delivery – Integrated Solutions pg 22-23 ▪ Process mapping
Services promote client centred treatment and recovery	▪ Develop relationships with organisations around CEP across the sector to align with: o Whanau Ora o Peer-based advocacy services	▪ All providers participate in the CEP development and ongoing monitoring	▪ P&F	▪ Ongoing	▪ Whanau Ora Guidelines ▪ Dual Diagnosis Capability Checklists

Goal 2: Service Development – services need to be responsive to CEP and to work towards being CEP capable					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Review of specialist FTE	▪ Review current FTE / need / reconfiguration ▪ Aligning CEP capable criteria to MRN qualifications project ▪ Develop a shared definition of CEP Enhanced Practitioners / CEP capable staff ▪ Explore expectations and scope of CEP Enhanced Practitioners role	▪ CEP specialists are employed across the sector ▪ Capture of outputs ▪ Non-clinical staff are provided with training, skills, coaching and co-working	▪ P&F ▪ Service Mgrs and Midland WFC	▪ 2011 ▪ 2012/1015	Service Delivery – Integrated Solutions ▪ Quadrants of care ▪ Specialist CEP clinicians ▪ Nationwide Service Framework
Developing of comprehensive local and regional plans & strategies to increase CEP awareness	▪ BOP plan is developed and implemented ▪ Midland Regional Plan developed and implemented	▪ All providers are involved in the development and implementation of the plans	▪ BOP focus group/stakeholders ▪ Midland RN Director & P&F	▪ 2011 ▪ 2010	

Goal 3. Integrated systems of care –systems are to acknowledge and incorporate CEP approaches					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Services are responsible for ensuring systems acknowledge & incorporate CEP	▪ Teams are CEP capable (supervision, professional development, MDT/Case Management)	▪ CEP formulation is integrated ▪ PRIMHD CEP reporting informs the sector ▪ Supervisors are CEP skilled ▪ Individual Professional Development Plans reflect CEP objectives	▪ Managers & Staff sector wide	▪ Ongoing	Service Delivery – Integrated Solutions: ▪ Information sharing ▪ Tips for MH&A managers and leaders

Goal 3. Integrated systems of care –systems are to acknowledge and incorporate CEP approaches					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Service leaders collaborate	▪ Identify & review opportunities of using existing forums to integrate CEP good practice: o Primary o MH o AoD o CAMHS o MHSOP } NGO PA IWI PHO	▪ Improved responsiveness to client, family whanau ▪ Improved relationships between providers	▪ Forum leaders	▪ 2011/2012	▪ Destination: Recovery Te Unga ki Uta: Te Oranga 2008

Goal 4: Workforce Development – a highly skilled workforce that is CEP responsive and effective					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Service support training initiatives provided nationally, regionally & locally	▪ Implement national initiatives ▪ Implement regional initiatives ▪ Identify additional workforce initiatives ▪ Take advantage of Scholarships: o Diploma CEP o Workforce Centres scholarships o Henry Bennett post graduate scholarships o Midland Regional Network scholarships	▪ Increase in number of staff trained ▪ Postgraduate training increased ▪ Increased uptake in relevant training ▪ Evaluation of training effectiveness is undertaken	▪ P&F ▪ Matua Raki ▪ WF Centre ▪ Midland WFC ▪ Sector	▪ Ongoing	▪ Service Delivery – Integration Solutions ▪ Workforce development ▪ Lets Get Real: http://www.moh.govt.nz/ ▪ Dual diagnosis Support Victoria: http://dualdiagnosis.ning.com/

TARANAKI DISTRICT HEALTH BOARD

4.4 Taranaki DHB Mental Health and Addictions Co-existing Problems Action Plan 2010 - 2015

Goal 1: Client Centred – a coherent and comprehensive understanding of the needs of tangata whaiora, whanau and families					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources required*
Documented Client Pathway from primary through to tertiary which is reflective of Whanau Ora is client centred and has a recovery focus.	▪ Development of agreed integrated pathway & policies and procedures. ▪ Development of Evaluation framework including: qualitative analysis; PRIMHD data, case-load reporting and audits.	▪ Linkages to existing and future projects e.g. MH&A Adult Continuum Project; CAHMS and Maternal Phase III Implementation; Provider Arm Acute Services review; Whanau Ora ▪ Service Development and pathways completed ▪ Agreed policies and procedures signed off by TLAG.	▪ Planning & Funding, Service Leaders and Managers.	▪ 2011-12	▪ Service Delivery – Integrated Solutions ▪ Client centred care pg 14-17 ▪ Tools for service development pg 22-23 ▪ Dual Diagnosis Checklist http://www.dualdiagnosis.ning.com/

Goal 2: Service Development – services need to be responsive to CEP and to work towards being CEP capable					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Integration of Mental Health and Addictions Services and any door is the right door.	▪ Cross Sector Service Level Agreements are developed. ▪ Development of Integrated Health Teams. ▪ Explicit link through the Primary / Secondary / NGO Mental Health and Addictions Demonstration Site Project to ensure primary sector CEP education and training.	▪ Qualitative Analysis ▪ Service Effectiveness from a clients perspective, service continuum (clinical), and organisational. ▪ Shared electronic files ▪ Increase in co-existing diagnosis. ▪ Enhanced Practitioner resources are in place.	▪ P&F, Service Leaders and Managers	▪ 2011-2012	▪ Service Delivery – Integrated Solutions ▪ Quadrants of care pg 13 ▪ Continuum of service capability pg 19 ▪ Service level agreements pg 21 ▪ Specialist CEP clinicians pg 20-25
Review of Specialist Dual Diagnosis FTE's	▪ Review current roles	▪ Enhanced Practitioner resources are in place.	▪ P&F	▪ 2011	

Goal 3. Integrated Systems of care –systems are to acknowledge and incorporate CEP approaches					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Services Collaborate	▪ Commitment at leadership and clinical governance level to lead collaboration. ▪ Review effectiveness of 'other' established and successful collaborations. Transferrable learning's.	▪ Effectiveness of leadership in other sector initiatives / projects /service development work in focusing on CEP.	▪ P&F, Service Leaders and Managers	▪ 2011 ongoing	▪ Service Delivery – Integrated Solutions ▪ Tips for MH&A managers and leaders pg 29-30 ▪ Integrated systems of care pg 23-24

Goal 4: Workforce Development – a highly skilled workforce that is CEP responsive and effective					
Objective	*Action*	*KPI*	*Responsibility*	*Completion Timeframe*	*Resources Required*
Staff across the sector are trained & supported to be CEP capable.	▪ Stock-take of current workforce skills base. ▪ Identify the training resources, nationally regionally and locally. ▪ Sharing of knowledge across the sector e.g. supervision and case-management. ▪ Long-term workforce development plan for up-skilling and training of staff. ▪ Identify future opportunities for CEP roll-out and training.	▪ Identify champions in each part of the sector. ▪ By 2015 75% of staff are CEP capable. ▪ Access to training is inclusive of the whole sector.	▪ P&F, Service Leaders and Managers ▪ Midland WFC	▪ Ongoing	▪ Service Delivery – Integrated Solutions ▪ Specialist CEP clinicians pg 20-25 ▪ Workforce development pg 24-26 ▪ Tools and resources national, regional and local